



STATE HEALTH INFORMATION GUIDANCE

SHARING BEHAVIORAL HEALTH INFORMATION IN CALIFORNIA



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Executive Summary

Healthcare providers in California frequently express concern about the impact complex health information laws have on their practices and ability to provide integrated and coordinated care for patients. This is particularly true for the stringent federal and State laws that provide special protections for the privacy and confidentiality of mental health and substance use disorder (SUD) patient information. The State of California developed this State Health Information Guidance (SHIG) document to help clarify existing (as of May 1, 2017) State and federal laws that impact disclosure and sharing of mental health and SUD patient information and records within California by providing scenario-based guidance in everyday business language. This guidance incorporates revisions to 42 Code of Federal Regulations (C.F.R.) Part 2 effective March 2017.

The SHIG document provides the State of California's guidance in plain language about how mental health and SUD protected health information can be shared in the day-to-day practice of providing patient-centered care. It is designed to clarify existing State and federal laws that impact disclosure and sharing of behavioral health information within California by providing scenario-based guidance in everyday business language. The SHIG includes a variety of common scenarios to answer questions regarding when mental health and SUD patient data can be appropriately disclosed with and without patient authorization. This guidance will help achieve the objectives of the Institute for Healthcare Improvement's Triple Aim Initiative: improve patient healthcare experience, improve the health of populations, and reduce the cost of healthcare.

The process of developing the SHIG involved extensive input from private and public healthcare entities. Stakeholders from more than 20 healthcare organizations served on the SHIG Advisory Group, identified common questions and concerns about sharing behavioral health information¹, and provided periodic feedback as the SHIG was developed. The scenarios included in the SHIG are based on questions and concerns identified by the stakeholders.

The guidance in this document involves five general principles the State of California considers foundational for sharing behavioral health information:

1. **Coordination of Care** - Behavioral health information should be shared to the extent allowed by federal and State law to address patient care needs involving medical, behavioral and even socioeconomic issues.
2. **Information Blocking** - Intentionally not sharing behavioral health information that can be legally and ethically shared to benefit the patient is strongly discouraged.

¹ For purposes of this document Behavioral Health is defined as mental health and substance use disorder patient information.

3. **Patient Access** - *A patient generally has the right to inspect, review, and obtain copies of his or her behavioral health information, and a provider is responsible to enable such patient access.*
4. **Patient Right to Be Informed** - *A patient generally has the right to be informed of a provider's practices regarding uses and disclosures of his or her healthcare information.*
5. **Patient Right to Authorize Disclosure of Healthcare Information** - *A patient has the right to authorize disclosure of his or her behavioral health information.*

Based on these principles and relevant federal and State law, the clarifying guidance in this document is organized to move from general to more specific guidance in three levels:

1. [General Guidance](#) to identify key federal and State laws regarding the disclosure of patient mental health information or SUD patient-identifying information, and help behavioral healthcare providers determine whether and when they and their patients' information are regulated by the complex mental health and SUD laws.
2. **Guidance by Category** in six situational categories
 - a. [Treatment and Coordination of Care](#)
 - b. [Payment and Determination of Benefits](#)
 - c. [Healthcare Business Operations](#)
 - d. [Law Enforcement](#)
 - e. [Public Safety and Public Health Policy](#)
 - f. [Health Information Exchange](#)
3. [Scenario-Based Guidance](#) to provide answers and clarifications to stakeholder-identified questions through flow-chart graphics and narrative responses for 22 scenarios.

State and federal regulations regarding the privacy of medical information in general, and behavioral health information specifically, clearly allow protected information to be shared for a wide variety of purposes when a patient or patient's authorized representative provides consent or authorization. Therefore, this behavioral health information guidance on exchange of patient information and records focuses on activities involving uses and disclosures of protected health information (PHI) that do not require authorization from the patient or an authorized representative.

While the guidance is designed to be helpful and authoritative, the SHIG is specifically not designed, nor does the State intend through its publication, to provide legal counsel applicable to all behavioral health circumstances. This guidance is for informational purposes only and should not be construed as legal advice or policy of the State of California. The State makes no warranties, expressed or implied, regarding errors or omissions and assumes no legal liability or responsibility for loss or damage resulting from the use of information contained within. Due to the complexity of laws related to mental health and SUD information and records, readers are

encouraged to consult legal counsel prior to developing and implementing operational policies and procedures governing the use and disclosure of such patient information.

This guidance document is not intended as a comprehensive solution for all the associated legal, technological, operational, cultural and financial issues associated with sharing specially protected mental health and SUD information. It is, however, intended to encourage the responsible and appropriate sharing of health information in California and promote a dialog among care providers and interested stakeholders regarding what disclosures and sharing can be done within current State and federal laws. Healthcare providers, patient advocates, coordinators of care, concerned individuals, the courts, local governments, community health centers, State agencies and the legislature must collaborate and dialog with one another to fully achieve this document's purpose. To protect patients' rights while promoting whole-person care and better patient health outcomes through improved care coordination and information sharing, this dialog must continue well beyond the SHIG's publication.

The State encourages readers to use the SHIG to take appropriate next steps for their organizations to improve patients' healthcare experiences and health outcomes. Possible next steps for readers might include:

- Sharing the SHIG with appropriate staff and leaders within the readers' healthcare organizations
- Reviewing and possibly updating organization policies and procedures
- Working with local government, other providers, and patients' groups to develop memoranda of understanding (MOU) and data-sharing agreements for Whole Person Care pilots and other appropriate patient care efforts involving data sharing
- Actively engaging in industry discussions regarding Triple Aim objectives and how to best achieve them
- Identifying legislative changes that protect patient privacy while limiting obstacles for patient-centric integrated care.

While designed to be helpful, the SHIG clarifications will lead to improvements for California healthcare providers and patients only if there is meaningful follow-up action.

Purpose of SHIG

This State Health Information Guidance (SHIG) combines general guidance and field-based scenarios to clarify federal and State behavioral health law related to sharing patient mental health and substance use disorder (SUD) patient-identifying information. The SHIG offers authoritative guidance to provide legal clarification for sharing patient information while protecting patient privacy. Removing obstacles may result in increased coordination of care to help patients achieve better health outcomes, but coordination of care requires patient information to be shared in an appropriate, secure, and timely manner between different types of health providers.

This SHIG provides non-mandatory, authoritative guidance from the State of California on the uses, disclosures and protection of sensitive patient information for non-state government entities. This guidance document is not designed to address all behavioral health information sharing challenges that California providers currently experience. Rather, it clarifies California statutes and federal regulations for a non-legal audience. The clarifications help inform providers and their support entities regarding when, why, and how sensitive mental health and SUD patient-identifying information may be shared among care partners.

State statutes and federal regulations regarding the privacy of medical information in general, and behavioral health information specifically; clearly allow protected information to be shared for a wide variety of purposes when a patient or patient's authorized representative provides consent or [authorization](#). Therefore, this behavioral health information guidance focuses on exchange of patient information and records involving uses and disclosures of [protected health information](#) that do not require authorization from the patient or the patient's authorized representative.

The intended audience of the SHIG is private sector healthcare providers, payers, vendors, healthcare associations, patient and privacy advocacy organizations, county governments, community health centers and other interested parties. General guidance and field-based scenarios are employed in the SHIG as a means to clarify applicable privacy laws in the context of common obstacles and opportunities currently experienced by providers. Both general guidance and scenarios are used to clarify the State's interpretation of patient legal protections in lay language for a general and broad audience of stakeholders.

This guidance document is not a restatement of current laws. Instead, the SHIG is designed to clarify existing State and federal laws that impact disclosure and sharing of behavioral health information within California by providing scenario-based guidance in everyday business language.

Background of SHIG

The State Health Information Guidance (SHIG) project was developed by the California Office of Health Information Integrity (CalOHII) and funded by the California Health Care Foundation (CHCF). CalOHII and CHCF collaborated on this important initiative in order to clarify the federal and State laws that address how and when patient information related to mental health and substance use disorders (SUD) can be exchanged with or without express patient authorization between behavioral healthcare providers and other providers involved in patient care.

CalOHII's primary mission is to assist State departments to protect and secure access to health information. CalOHII created this non-binding guidance because of its statutory authority to interpret and clarify State law, and because it produced the [Statewide Health Information Policy Manual \(SHIPM\)](#). The SHIPM provided similar guidance for California State department entities covered by the Health Insurance Portability and Accountability Act. The SHIPM, originally published in 2015, is updated annually and in use today.

This SHIG was developed to promote greater care integration and coordination through secure information sharing between providers of mental health treatment, (SUD) treatment, and other healthcare. The goal of the document is to address stakeholder challenges in interpreting federal and State privacy laws protecting behavioral health patient information. Clarifying and providing the State's guidance regarding such laws will improve patient health, improve quality of care and perhaps lower costs in California. The chosen approach to clarify federal and State privacy laws is creation of the SHIG.

The process for developing the SHIG was initiated when CalOHII invited stakeholders from across the California healthcare industry to participate in the launch of the project in September 2016. Feedback was solicited about current obstacles to sharing behavioral health information. Below are samples of stakeholder comments at the meeting that reflect the wide range of perspectives the SHIG is addressing:

- ✓ "The laws are nebulous on what can and can't be shared."
- ✓ "Top level funding through the State requires integrated sharing of patient information. On the other hand, we have a legal system saying you can't do that!"
- ✓ "Trust levels between providers, patients, payers, and vendors are low."
- ✓ "We are missing the patient's voice. The patients say they want providers to share information."

Stakeholder recommendations for SHIG content and approach included:

- ✓ Stakeholders believe that data sharing is essential to achieving the Triple Aim² (better health, better care, lower costs) and supporting the shift toward holistic, proactive care that is central in current health reform efforts in California and nationally.
- ✓ Stakeholders hope that SHIG will address key questions and gray areas that currently impede data sharing at both the practice and systems levels.
- ✓ Stakeholders recommended that SHIG include real life examples of what is currently allowable when sharing patient information related to behavioral healthcare.

Advisory Group members were selected from the more than 20 participating organizations to assist and provide feedback to the project. See [Appendix 1](#) for a list of participants. CalOHII convened the first Advisory Group meeting in Sacramento in November 2016. The Advisory Group members developed almost 50 user stories based on their professional experiences with the issues, obstacles and opportunities associated with sharing patient information and coordinating care. The user stories helped inform the development of field-based scenarios to clarify federal and State laws.

CalOHII sought additional input to guide the SHIG project by initiating discussions with a number of statewide and national advocacy organizations. A list of participants who provided additional input is included [Appendix 1](#) of this document. Their comments included:

PATIENT RIGHTS AND PRIVACY

- ✓ “There is pressure to move sensitive patient information around the healthcare super highway”
- ✓ “The patient’s dignity must be at the core of all decisions.”
- ✓ “Can we really know what happens to the patient data after it has been shared?”

PATIENT ACCESS TO CARE

- ✓ “The caregiver’s attempt to coordinate with physicians and law enforcement is hampered because of the lack of information sharing. The other entities are reluctant to share patient information with caregivers who are responsible for their daily care.”
- ✓ “(Some) mental health providers are very resistant to share any information. In our opinion, they are sometimes not in alignment with the patient’s rights.”

² Institute for Healthcare Improvement, “Triple Aim Initiative,” 2017, <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

SHIG was informed by the conclusions of two helpful publications (links to both included in [Appendix 3](#)):

- [*Fine Print: Rules for Exchanging Behavioral Health Information in California in 2015*](#)

This thoughtful CHCF-sponsored white paper describes misconceptions about State and federal laws governing disclosure of behavioral health information and identified the need for State clarification to ease provider confusion as they interpret and apply privacy laws.

- [*Getting the Right Information to the Right Health Care Providers at the Right Time – A Road Map for States to Improve Health Information Flow between Providers*](#)

This National Governor’s Association document describes market and legal barriers that inhibit the exchange of patient health information and outlines approaches for states to provide better care coordination through patient information exchange, including publication of regulatory guidance. California Health and Human Services and CalOHII have taken the guidance approach through development of the SHIG.

To help meet the objective of clarifying statutes and regulations relating to mental health and substance use disorder, attorneys from the State and Advisory Group organizations reviewed draft content periodically throughout the development of the SHIG. They provided essential legal feedback at various review milestones and during the final review of the completed document.

CONCLUSION

One of the main objectives of the SHIG is to promote better care integration and better health outcomes for mental health and SUD patients while protecting their privacy. Through feedback received via its “grass roots” stakeholder engagement method, CalOHII believes the greatest value of the SHIG is its clarification of federal and State laws regarding mental health and substance use disorder (SUD) health information by translating the complex laws into non-legal and non-technical language for a general audience. The hope is clarity will lead to more integrated care and better outcomes.

Navigating SHIG

This section is designed to orient the reader to the State Health Information Guidance (SHIG) document. It explains the imbedded hyperlinks, the structure of the guidance, and the approach to legal citations and references.

Definitions, Acronyms and Hyperlinks

Beginning with this section and throughout the rest SHIG, key words, phrases and acronyms are underlined and in blue font the first time they are used in a section. As an example, note the formatting of [protected health information \(PHI\)](#). Words and phrases formatted in this way are hyperlinks to definitions presented in [Appendix 4](#). All forms of a word are included under one definition (e.g., patient, patients, and patient’s would all be listed under “patient” in the definitions). If the reader is using an electronic version of the document, a click on the link will take the reader to the appropriate SHIG definition. Acronyms and the phrase each acronym represents are listed in [Appendix 5](#).

In addition to words, phrases and acronyms, the titles of specific sections of the SHIG (or of reference documents included in the appendices) may also have the same formatting and are also hyperlinks. A click on the link when using an electronic version of SHIG will take the reader to the section of the document referenced. As examples, see the links to [Appendix 4](#) and [Appendix 5](#) here and in the paragraph above.

Lastly, the [Table of Contents](#) is also a navigation tool. In electronic versions of the SHIG, the reader may click on a section defined in the [Table of Contents](#) and be taken to the beginning of the section selected.

Structure of Guidance

The guidance in this document is organized to move from general to more specific guidance:

- [General Guidance](#) – This is the most general information on overall healthcare and behavioral health information [privacy](#) laws.
- **Guidance by Category** – The design of each Guidance by Category section is to present with simplicity a few paragraphs of high-level guidance that apply to all the scenarios in a category. There may be exceptions to the high-level guidance and additional detail presented in the specific scenarios within the category. The behavioral health information guidance scenarios are presented in six categories:
 1. [Treatment and Coordination of Care](#)
 2. [Payment and Determination of Benefits](#)
 3. [Healthcare Business Operations](#)
 4. [Law Enforcement](#)

[5. Public Safety and Public Health Policy](#)

[6. Health Information Exchange](#)

- **Scenario-based Guidance** – This is guidance that addresses specific questions for each of the scenarios within a category. Each scenario answers a specific behavioral health information [disclosure](#) question raised by SHIG stakeholders. It is an illustrated Questions & Answers (Q&A) for common issues regarding disclosure of behavioral health information.

Many of the scenarios focus on the criteria for sharing information without a patient [authorization](#). When authorizations are required by law, providers are encouraged to discuss with patients why some forms of sharing are in the patients' best interests. Informed disclosure decisions by patients are often strongly beneficial.

Each scenario has four parts:

- a brief description of the scenario
- a graphic illustrating the State's guidance for the scenario
- a narrative describing the State's guidance specific to the scenario
- a list of relevant legal citations and references

Some of the scenario graphics feature a landscape layout for readability purposes.

Role-Based Navigation

For the convenience of the reader, the table on the next page identifies the most common provider and healthcare industry roles included in the scenarios and which scenarios are relevant for each role. Readers viewing an electronic version of the document can click on the X within the table and jump to the appropriate scenario.

Table of Navigation Links to Scenarios by Role

	Scenario Name	Mental Health	SUD	Physical Health	Social Services	Emergency Personnel	Care Coord	Law Officer	HIO	Bus Ascc	Public Health
1	Behavioral Health (BH) to Physical Health	<u>X</u>	<u>X</u>	<u>X</u>							
2	Physical Health to BH	<u>X</u>	<u>X</u>	<u>X</u>							
3	BH to Other BH	<u>X</u>	<u>X</u>								
4	BH to Social Services	<u>X</u>	<u>X</u>		<u>X</u>						
5	Mental Health (MH) Provider to Caregiver	<u>X</u>					<u>X</u>				
6	Substance Use Disorder (SUD) Provider to Caregiver		<u>X</u>				<u>X</u>				
7	To Improve Coordination of Care	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>				<u>X</u>
8	In the Event of Emergency	<u>X</u>	<u>X</u>	<u>X</u>		<u>X</u>					
9	BH to Social Services for Payment and Determination of Benefits	<u>X</u>	<u>X</u>		<u>X</u>						
10	Quality Improvement	<u>X</u>	<u>X</u>	<u>X</u>						<u>X</u>	
11	Audits	<u>X</u>	<u>X</u>							<u>X</u>	
12	Business Associates	<u>X</u>	<u>X</u>							<u>X</u>	
13	BH Organization Policy and Strategy Development	<u>X</u>	<u>X</u>							<u>X</u>	
14	Law Enforcement Official Requesting Info from SUD		<u>X</u>					<u>X</u>			

	Scenario Name	Mental Health	SUD	Physical Health	Social Services	Emergency Personnel	Care Coord	Law Officer	HIO	Bus Assc	Public Health
15	Law Enforcement Official Requesting Info from MH	<u>X</u>						<u>X</u>			
16	Patient Being Released from Involuntary Hospitalization	<u>X</u>						<u>X</u>			
17	Public Health and Safety	<u>X</u>	<u>X</u>	<u>X</u>				<u>X</u>			
18	Public Health Policy Development	<u>X</u>	<u>X</u>								<u>X</u>
19	SUD Provider to Health Information Organization (HIO)		<u>X</u>						<u>X</u>		
20	MH Provider to HIO	<u>X</u>							<u>X</u>		
21	SUD Info from HIO to Recipient		<u>X</u>						<u>X</u>		
22	MH Info from HIO to Recipient	<u>X</u>							<u>X</u>		

Legal Caveat

The SHIG provides the State of California's non-mandatory guidance regarding disclosure of patient information related to behavioral healthcare. It is designed to clarify existing State statutes and federal laws that impact [disclosure](#) and sharing of behavioral health information within California by providing scenario-based guidance in everyday business language.

While the guidance is designed to be helpful and authoritative, the SHIG is specifically not designed, nor does the State intend through its publication, to provide legal counsel. This is for informational purposes only and should not be construed as legal advice or policy of the State of California. The CalOHII makes no warranties, expressed or implied, regarding errors or omissions and assumes no legal liability or responsibility for loss or damage resulting from the use of information contained within. Due to the complexity of laws related to patient [mental health information](#) and [SUD patient-identifying information](#), readers are encouraged to consult legal counsel prior to developing and implementing operational policies and procedures governing the use and disclosure of such patient information.

The SHIG provides non-binding clarification to help readers working with behavioral health information better understand relevant sections of State and federal [privacy](#) laws including, but not limited to, the:

- Health Insurance Portability and Accountability Act (HIPAA)
- Confidentiality of Substance Use Disorder Patient Records - 42 C.F.R. Part 2 (as revised March 2017)
- Confidentiality of Medical Information Act (CMIA)
- Information Practices Act (IPA)
- Lanterman-Petris-Short Act (LPS)
- California Civil Code
- California Code of Regulations Title 9 – Rehabilitative and Developmental Services
- California Constitution, Article 1 § 1
- California Health and Safety Code (HSC)
- California Welfare and Institutions Code (WIC)
- Patient Access to Health Records Act (PAHRA)

General Guidance

The State of California encourages multi-disciplinary [coordination of care](#) for people receiving [treatment](#) and services in California. There is a growing consensus in the healthcare community that such integrated “whole person” care improves treatment outcomes, reduces inefficient use of healthcare resources, and increases patient satisfaction and safety.

At the same time, the State acknowledges the importance of protecting the [privacy](#)³ of patients and the [confidentiality](#) of healthcare information. Many patients have needlessly experienced the pain of ostracization or discrimination due to the inappropriate [disclosure](#) of information regarding their mental health or substance use disorder (SUD) treatments. Protecting patients from this type of violation of their privacy rights is the driving force behind the special regulatory protections for mental health and SUD patients’ healthcare records and information⁴.

A dynamic tension exists between the needs to effectively care for patients and to protect the sensitive behavioral health information from inappropriate disclosure. This tension led directly to the State’s use of the principles articulated in the following section to develop this behavioral health information guidance.

Principles for Sharing Behavioral Health Information

The following general principles are considered foundational by the State of California for sharing behavioral health information and records.

1. *Coordination of Care*

Principle - Behavioral health information should be shared to the extent allowed by federal and State laws to address patient care needs involving medical, behavioral and even socioeconomic issues.

People with behavioral health needs frequently require [treatment](#) through a variety of professional disciplines. A multi-disciplinary approach may be required to fully address the patient’s care needs. Such an approach (e.g., State of California [Whole Person Care](#) pilots⁵) is likely to require the exchange of legally permitted behavioral health information and such sharing is encouraged. The goal of this type of information exchange is to provide collaborative integrated care that leads to “improving the patient experience of care (including quality and

³ California Constitution, Article 1 §1

⁴ 42 C.F.R. § 2.3(b)(2).

⁵ Authorized by the Medi-Cal 2020 Section 1115(a) Waiver [CA Welfare and Institutions Code § 14184.60(c)(5).]

satisfaction); improving the health of populations; and reducing the per capita cost of healthcare.”⁶

2. Information Blocking

Principle – Intentionally not sharing behavioral health information that can be legally and ethically shared to benefit the patient is strongly discouraged.

Blocking exchange of or choosing not to disclose information when doing so is clearly in the best interests of the patient and allowed by law is generally discouraged. Providers of behavioral healthcare services generally have a responsibility to develop a therapeutic relationship with a patient and that may appropriately lead to limiting the disclosure of patient information, such as information protected by the psychotherapist/patient privilege. Within the scope of this responsibility, however, providers are encouraged to discuss with patients why some forms of sharing might be in the patients’ best interests. Informed disclosure decisions by patients are often strongly beneficial. If the sharing of patient information is legally permissible, beneficial to and unopposed by the patient, blocking such disclosures for purposes of a provider’s financial gain, leverage in negotiations, or to otherwise achieve competitive advantage in the healthcare marketplace is inappropriate and increases the risk of unethically elevating the provider’s interests above the best interests of the patient.

3. Patient Access

Principle – A patient generally has the right to inspect, review, and obtain copies of his or her behavioral health information, and a provider is responsible to enable such patient access.

A patient’s right to be informed generally holds whether the healthcare information is held by mental health, SUD, or other entities and [business associates](#) covered by the Health Insurance Portability and Accountability Act (HIPAA). In certain circumstances involving behavioral health records, however, [access](#) to information may be denied after review by a licensed healthcare professional. An example of such an appropriate denial of access would be if there is a substantial risk of significant adverse or detrimental consequences to the behavioral health patient or another person.

4. Patient Right to Be Informed

Principle – A patient generally has the right to be informed of a provider’s practices regarding uses and disclosures of his or her healthcare information.

A patient has a general right to receive notifications regarding how a health provider or organization plans to use and disclose patient health information, even when not specifically

⁶ Institute for Healthcare Improvement, “Triple Aim Initiative,” 2017, <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

addressed in State regulations. HIPAA [privacy](#) regulations provide additional guidance on how to accomplish this, including through the [Notice of Privacy Practices](#).

5. Patient Right to Authorize Disclosure of Healthcare Information

Principle – A patient has the right to authorize disclosure of his or her behavioral health information.

An adult patient generally may provide permission for a provider or organization to share his or her personal healthcare information, including behavioral healthcare records, for a wide variety of purposes. When in the best interests of the patient and allowed by law, the State strongly encourages the exchange or disclosure of information. Even when State and federal statutes and regulations prohibit disclosure of healthcare information unless authorized, behavioral healthcare providers are encouraged to discuss with patients why authorizing a disclosure or the sharing of information may be in the patients' best interests. Examples might include situations where a patient can authorize disclosure and sharing of information to encourage collaboration and integrated care between [SUD treatment programs](#), behavioral healthcare providers, physical health entities, and providers of social services.⁷

⁷ Additional information regarding patient authorizations may be found in [Appendix 2](#) of this document.

Introduction to Behavioral Health Information Guidance

The State believes appropriate exchange of [behavioral health](#) information can be achieved to effectively provide a patient with coordinated and integrated care while still protecting the patient's right to [privacy](#). The State also understands many behavioral healthcare providers choose not to share patient information that is legally permitted to be [disclosed](#) and exchanged due to the complexity and lack of clarity of current federal and State law and fear of non-compliance.

The purposes of behavioral health information guidance are to:

1. Clarify how and when patient behavioral health information can be shared
2. Increase willingness to appropriately exchange patient information in the behavioral health professional community

For purposes of the State Health Information Guidance (SHIG), "behavioral health" is defined as the assessment, diagnosis or [treatment](#) of:

- Mental Health
- Substance Use Disorders (SUD)

The sharing of health information means the [access](#) to, use, disclosure and exchange of patient information and records between two or more individuals or organizations. There are four types of information that this document covers:

1. Information regulated by the Confidentiality of Substance Use Disorder Patient Records - 42 C.F.R. Part 2 (as revised March 2017)
2. Information regulated by the Health Insurance Portability and Accountability Act (HIPAA)
3. Information regulated by the Lanterman-Petris-Short (LPS) Act
4. Information regulated by the Confidentiality of Medical Information Act (CMIA)

State and federal statutes and regulations regarding the privacy of medical information in general, and behavioral health specifically, clearly allow [protected health information](#) to be shared for a wide variety of purposes when a patient or patient's authorized representative provides consent or [authorization](#). Therefore, this behavioral health information guidance on exchange of patient information and records will focus on activities involving uses and disclosures of [protected health information](#) that do not require authorization from the patient or the patient's authorized representative. Additional information regarding authorization may be found in [Appendix 2](#) of this document.

Generally Applicable Guidance

There are numerous State and federal regulatory factors to consider when sharing patient health information. The [Guidance for Specific Scenarios](#) section of this document provides guidance specific to the circumstances of each scenario. Some guidance, however, applies quite broadly to a variety of situations. The following five subsections provide broad guidance that generally applies to all the scenarios. Since these five areas of guidance apply broadly, the topics are not repeated in individual scenarios to avoid duplication for the reader.

Minimum Necessary

When health information is requested, used, or disclosed, steps must be taken to limit the information only to what is relevant and necessary to accomplish the intended purpose. The [minimum necessary](#) requirement does not apply to:

- Disclosures to or requests by a healthcare provider for treatment purposes
- Disclosures made to the patient who is the subject of the record, when requested or required
- Uses or disclosures made pursuant to a valid patient [authorization](#)
- Disclosures to the Secretary of the U.S. Department of Health and Human Services
- Uses or disclosures required by State or federal law

[45 C.F.R. § 164.502(b).]

Documentation Requirements for Authorized Disclosures

Specific documentation must be created and maintained for [disclosures](#) of patient health information regulated by 42 C.F.R. Part 2 and LPS, even when legally authorized by the patient.

All disclosures of SUD patient-identifying information regulated by 42 C.F.R. Part 2 must be documented and provided to the patient upon request. A written statement must accompany each disclosure of SUD patient-identifying information regulated by 42 C.F.R. Part 2.

When LPS-regulated mental health records are shared for any reason outside the treatment facility or program, the disclosure must be documented in the patient's medical records. The disclosure documentation must include the date, circumstance, names of recipient, relationship to patient, and what information was disclosed. Mental health information shared between [qualified professional persons](#) employed by the same program with medical or psychological responsibility for the patient's care need not be documented in the patient's medical records.

[42 C.F.R. § 2.13(d); 42 C.F.R. § 2.51(c); CA Welf. & Inst. § 5328(a) and (b); CA Welf. & Inst. § 5328.6.]

See [Appendix 2](#) for more detailed documentation requirements for authorized disclosures.

Re-Disclosure of LPS and 42 C.F.R. Part 2 Patient Information

Mental health and SUD patient information regulated by LPS and 42 C.F.R. Part 2 is specially protected and, once received, may only be re-disclosed under specific conditions. Health information that identifies a patient directly or indirectly as having been diagnosed, treated or referred for treatment for a substance use disorder requires each disclosure be made with written consent from the patient or patient's representative. The recipient of the disclosed information cannot make further disclosure unless additional disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Mental health information covered by LPS may be re-disclosed provided the recipient has responsibility for the patient's medical or psychiatric care.

[42 C.F.R. § 2.31(a); 42 C.F.R. § 2.32; 45 C.F.R. § 2.35; CA Welf. & Inst. § 5328(a); CA Health & Saf. § 11845.5(c)(1).]

Psychotherapy Notes

Psychotherapy notes are defined as notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. While psychotherapy notes are referenced in HIPAA, they are not referenced in California law. Based on HIPAA, psychotherapy notes may generally not be released without patient authorization.

[45 C.F.R. § 164.501.]

De-identified Information and Limited Data Set

To protect patient privacy while providing useful healthcare data, alternative approaches are permitted by current statutes and regulations. Alternative approaches include the use of de-identified information or a limited data set.

The HIPAA Privacy Rule specifies two requirements for the de-identification of health information:

1. A formal determination by a qualified expert
2. The removal of specified individual identifiers as well as absence of actual knowledge by the covered entity that the remaining information could be used alone or in combination with other information to identify the individual

A covered entity meets the HIPAA de-identification standard by satisfying one of the two de-identification requirements. De-identified health information created following one of these methods does not fall within the definition of protected health information (PHI).

Working with a limited data set rather than de-identified data may have more value to a covered entity, depending on the intended use of the data. A limited data set is health

information that excludes the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

- Names
- Postal address information
- Telephone and Fax numbers
- Electronic Mail addresses
- Social Security Numbers
- Medical record numbers
- Health Plan beneficiary numbers
- Account numbers
- License / certification numbers
- Vehicle identification numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Internet Protocol (IP) addresses
- Biometric identifiers
- Full face photographic images

A covered entity may use or disclose a limited data set only for the purposes of public health, research, or healthcare operations if the covered entity enters into a data use agreement with recipient of the limited data set. A covered entity may use PHI to create a limited data set, or disclose PHI to a business associate or qualified service organization for such purpose.

[45 C.F.R. § 164.514(e).]

Since the preceding five areas of guidance apply broadly to the scenarios, the topics are not repeated in individual scenarios.

Summary of Primary Laws

[Mental health information](#) and [substance use disorder \(SUD\) patient-identifying information](#) are specially protected types of health information. There are a number of federal and State laws specifically pertaining to these types of health information.

The primary Federal regulations affecting the uses and [disclosures](#) of behavioral health information include:

- 42 Code of Federal Regulations (C.F.R.) Part 2 (as revised March 2017) – Confidentiality of Substance Use Disorder Patient Records
- 45 C.F.R. Parts 160-164 – Health Insurance Portability and Accountability Act (HIPAA)

The primary State statutes pertaining to the uses and disclosures of behavioral health information include:

- CA Civil Code § 56 et seq. – Confidentiality of Medical Information Act (CMIA)
- CA Welfare and Institutions Code (WIC) – various, including the Lanterman-Petris-Short (LPS) Act at § 5328 et seq.
- CA Health and Safety Code (HSC) including § 11845.5, § 123110 and § 123125
- CA Code of Regulations Title 9 - Rehabilitative and Developmental Services including § 10568(c)

Following is the State's interpretation of these regulations and laws related to the access, use and disclosure of behavioral health patient information. The [Guidance for Specific Scenarios](#) section provides additional details and examples.

Overall Healthcare Privacy and Security Laws

Federal

HIPAA Privacy Rule (45 C.F.R. § 164.500 et seq.)

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to [health plans](#), healthcare clearinghouses, and those healthcare providers that conduct certain healthcare transactions electronically. The Rule requires appropriate safeguards to protect the [privacy](#) of personal health information, and sets limits and conditions on the uses and disclosures of such information without patient [authorization](#). Generally, exceptions are allowed for treatment, payment and healthcare operations. The Rule also gives patients' rights over their health information, including rights to [access](#), examine and obtain a copy of their health records, and to request corrections.

HIPAA Security Rule (45 C.F.R. § 164.300 et seq.)

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a [covered entity](#) or its [business associate](#)(s). The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the [confidentiality](#), [integrity](#), and [availability](#) of electronic [protected health information](#).

State of California

Confidentiality of Medical Information Act (CMIA) - Civil Code § 56.10-56.16

This law protects the [privacy](#) of medical information by limiting disclosures by providers of healthcare, healthcare service plans, and contractors. Disclosure of limited health information including location, general condition or death may be released to family members, other relatives, domestic partners, close personal friend or other person identified by the patient.

Substance Use Disorder Privacy Laws

Federal

Confidentiality of Substance Use Disorder Patient Records - 42 C.F.R. Part 2

42 C.F.R. Part 2 applies to federally assisted substance use disorder programs that meet the definition of a 'program.' Regulations apply to information that would identify a patient as having a substance use disorder (SUD) and allow very limited disclosures of information without patient [authorization](#).

State of California

Information and Records for Substance Use Disorder - CA HSC § 11845.5

Information and records maintained in connection with SUD diagnosis and treatment is confidential and specially protected under this code section. Information and records may be disclosed only as provided in this code section.

Rehabilitative and Developmental Services - CA Code of Regulations Title 9 § 10568(c)

All information and records obtained from or regarding residents in **Residential or Drug Abuse Recovery and Treatment facilities licensed by the State of California** shall be confidential and maintained in conformity with Title 42, Subchapter A, Part 2 Sections 2.1 through 2.67-1, Code of Federal Regulations. Facilities licensed in California to provide Alcohol and Other Drug services are required to follow 42 C.F.R. Part 2 regulations.

Mental Health Privacy Laws

State of California

Lanterman-Petris-Short (LPS) Act – CA WIC § 5328 – 5328.9

Information and records obtained in the course of providing mental health services to involuntarily detained recipients of services are confidential and specially protected under this code. Information and mental health services rendered by State hospitals and community mental health clinics are also protected under this code. Information and records may be [disclosed](#) only as provided in this code section.

Who is Subject to 42 C.F.R. Part 2 - Confidentiality of SUD Patient Records?

In order to be subject to 42 C.F.R. Part 2 an entity or provider must be both federally assisted and meet the definition of a 'program.' The provider is a 'program' if it promotes itself as offering substance use disorder services and provides or makes referrals for substance use disorder services.

For-profit programs and private practitioners who only accept private insurance or self-pay patients are not subject to 42 C.F.R. Part 2 regulations except when licensed by the State of California.

In California under CA Code of Regulations Title 9 § 10568(c) all information and records obtained from or regarding residents in **Residential or Drug Abuse Recovery and Treatment facilities licensed by the State of California** shall be confidential and maintained in conformity with Title 42, Subchapter A, Part 2 Sections 2.1 through 2.67-1, Code of Federal Regulations.

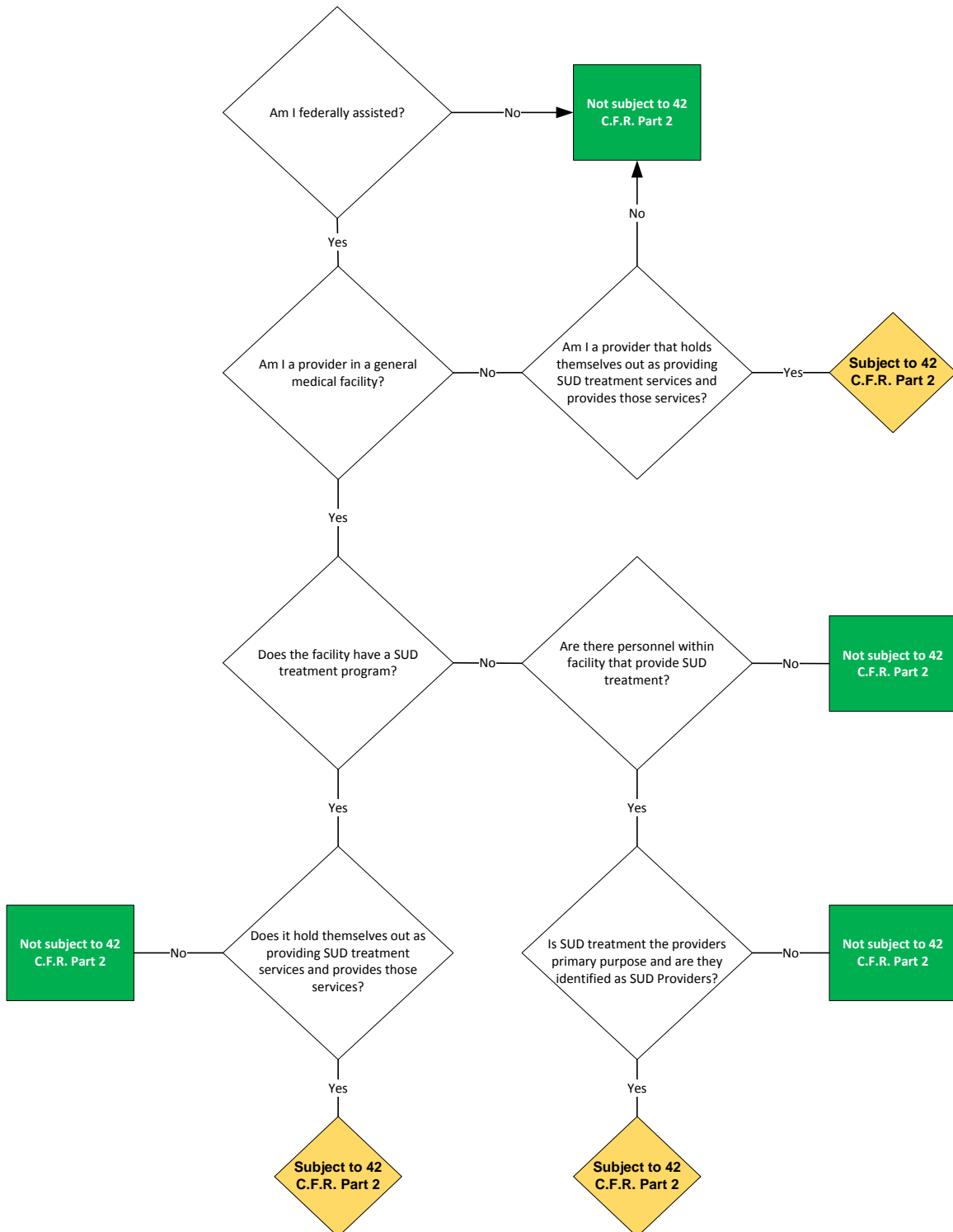
[Federally Qualified Health Centers \(FQHC\)](#) typically are not considered a 'program' by definition. If the FQHC is licensed by the State of California under CA Code of Regulations Title 9 § 10568(c), the FQHC would be subject to 42 C.F.R. Part 2 regulations.

Am I Federally Assisted?

42 C.F.R Part 2 regulations define a 'program' as federally assisted if any of the follow applies:

- The program is authorized to conduct business by any agency or department of the federal government of the United States
- The program is licensed, certified, registered, or authorized by any department or agency of the United States including but not limited to:
 - Participating as provider in the Medicare or Medicaid program
 - Authorized to conduct maintenance treatment or withdrawal management
 - Registered with the Drug Enforcement Agency (DEA) to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of substance use disorders (SUD)
- The program is supported by funds provided by any department or agency of the United States by being:
 - A recipient of federal financial assistance in any form, including financial assistance which does not directly pay for the SUD diagnosis, treatment, or referral for treatment
 - Conducted by a state or local government unit through revenue sharing or other forms of assistance, receives federal funds which could be but not necessarily spent for the [SUD treatment program](#)
- The program is assisted by the Internal Revenue Service (IRS) by being:
 - Allowed income tax deductions for contributions to the program or
 - Granted tax exempt status

Am I a 'Program' Under 42 C.F.R. Part 2



Who is Subject to the Lanterman-Petris-Short Act?

The Lanterman-Petris-Short (LPS) Act provides guidelines for ‘involuntary’ civil commitments of individuals to mental health institutions in the State of California. The act was intended to protect the civil rights of individuals by eliminating the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, development disabilities, and chronic alcoholism. The passing of the LPS Act brought an end to judicial commitments that provided no due process and the loss of civil and constitutional rights. If the provider is subject to LPS, it must comply with the law. The table below will help the reader determine if a provider is subject to the law and if not, which law would apply.

Entity	Subject to LPS	Subject to CMIA
Do you treat behavioral health patients that have been committed involuntarily (CA Welf. & Inst. § 5150 et seq.)?	Yes	
Do you treat behavioral health patients that have been committed involuntarily (CA Health & Saf. 1799.111.)?	No	Yes
Are you a state mental hospital?	Yes	
Are you a community program (refer to your legal counsel)?	Yes	
Are you a community program (CA Welf. & Inst. §§ 4000-4390 and 6000-6008)?	Yes	
Are you a county psychiatric ward, facility or hospital?	Yes	
Are you a Federal hospital, psychiatric hospital or unit?	Yes	
Are you a mental health rehabilitation center (CA Welf. & Inst. § 5675)?	Yes	
Are you a private institution, hospital, clinic or sanitarium which is conducted for the care and treatment of persons who are mentally disordered?	Yes	
Are you a psychiatric health facility (CA Health & Saf. § 1250.2)?	Yes	
Are you a skilled nursing facility with a special treatment program service unit for patients with chronic psychiatric impairments?	Yes	
Are you a private facility and treat patients that are voluntarily committed?	No	Yes

Resolving Differences in Statutes and Regulations

There are situations when statutes and regulations differ in their requirements regarding when, where and how disclosure of specially protected information is allowed or required. In such cases a preemption analysis was completed. Generally, the statute or regulation providing greater protection of patients' PHI or greater patient access to PHI takes precedence.

Although there are exceptions, the Summary Table of State Guidance by Key Law illustrates at a high-level which law generally applies to which type of behavioral health records and information. Even if patient health information is not covered by LPS or 42 C.F.R. Part 2, providers are still responsible for complying with HIPAA or CMIA.

Summary Table of State Guidance by Key Law

This section presents the State's general interpretation regarding the disclosure of behavioral health information for specific purposes. The following table that begins on the next page provides:

- Category/Purpose – This ties to the categories in the Scenario Guidance section and describes the high-level purpose of the disclosure or sharing of the information
- State Guidance – This presents the general State guidance specific to each behavioral health type (mental health and substance use disorder) as well as key general healthcare privacy laws that apply to behavioral health. Also presented are legal references on which the State's general guidance is based.

More detailed State guidance is provided in the [Scenario Guidance](#) section.

State Health Information Guidance

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<i>Business Operation</i> For health oversight activities	Mental health information may be disclosed to the California Department of Health Care Services for mental health quality assurance purposes. <i>[CA Welf. & Inst. § 5328.15.]</i>	Substance use disorder information can be disclosed to qualified personnel for management audits, financial and compliance audits or program evaluation, as long as any report on such activities does not identify patient identities in any way. <i>[42 C.F.R. § 2.2(b)(2)(B), § 2.52, and § 2.53; CA Health & Saf. § 11845.5(c)(3).]</i>	Behavioral health information may be disclosed to a person or entity that provides billing, claims management, medical data processing or other administrative services; information is limited to the minimum necessary to accomplish the intended purpose. <i>[45 C.F.R. § 164.501, §164.502, and § 164.512(d).]</i>	Behavioral health information may be disclosed to a person or entity that provides billing, claims management, medical data processing or other administrative services. <i>[CA Civ. Code § 56.10(c)(3).]</i>

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<p><i>Inform</i></p> <p>To inform family members of patient presence or status in a treatment facility</p>	<p>If the patient is unable to authorize the release of information (all attempts are noted or documented in the treatment record and daily efforts to secure the consent or refusal), only information confirming the patient's presence in the facility shall be provided upon request of a family member (spouse, parent, child, or sibling of a patient). [CA Welf. & Inst. § 5328.1(a).]</p>	<p>Presence of a patient in a treatment facility when the facility is not publicly identified as only alcohol and substance abuse may be disclosed. [42 C.F.R. §§ 2.13(c)(1) and 2.13(c)(2).]</p>	<p>Disclosure of limited health information including location, general condition or death is permitted to a family member, other relative, domestic partner, close personal friend, or other person identified by the patient. [45 C.F.R. § 164.510(b).]</p>	<p>Disclosure of limited health information including location, general condition or death is permitted to a family member, other relative, domestic partner, close personal friend, or other person identified by the patient. [CA Civ. Code § 56.1007.]</p>

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<p><i>Inform</i></p> <p>To inform others of patient activities in a 24-hour public or private treatment facility</p>	<p>The facility shall make reasonable attempts to notify the patient's next of kin or other person designated by the patient, of the patient's admission, release, transfer, serious illness, injury, or death only upon request of the family member, unless the patient requests that this information not be provided. [CA Welf. & Inst. § 5328.1(b).]</p>	<p>Presence of a patient in a treatment facility when the facility is not publicly identified as only alcohol and substance abuse may be disclosed provided substance use disorder identifying patient information is not disclosed. [42 C.F.R. §§ 2.13(c)(1) and 2.13(c)(2).]</p>	<p>Disclosure of limited health information including location, general condition or death is permitted to a family member, other relative, domestic partner, close personal friend, or other person identified by the patient. [45 C.F.R. § 164.510(b).]</p>	<p>Disclosure of limited health information including location, general condition or death is permitted to a family member, other relative, domestic partner, close personal friend, or other person identified by the patient. [CA Civ. Code § 56.1007.]</p>

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<i>Inform</i> To inform the patient's attorney	Mental health information may be disclosed without a written release of information if, in the professional judgment of the mental health staff, the patient lacks capacity to sign the release. <i>[CA Welf. & Inst. § 5328(j).]</i>	42 C.F.R. and CA Health and Safety Code do not address this specifically.	Mental/Behavioral health information may be shared with a patient's personal representative provided they have the legal authority to make healthcare decisions on behalf of the patient. <i>[45 C.F.R. § 164.502(g).]</i>	CA Civil Code and CA Health and Safety Code do not address this specifically.

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<p><i>Inform</i></p> <p>To inform Law Enforcement</p>	<p>Under limited circumstances, if patient is released from a 72 hour hold or a 14 day treatment hold and a request was made for notification of release by law enforcement who placed the patient on hold.</p> <p><i>[CA Welf. & Inst. § 5328(p).]</i></p>	<p>Confirming the identify of a patient who is not or has never been a patient in a 42 C.F.R. Part 2 regulated facility while remaining silent on the identity of a current patient can inadvertently compromise patient privacy. It is best to neither confirm nor deny the presence of a patient. Exceptions are made for a crime on the Part 2 premises or in the case of child abuse.</p> <p><i>[42 C.F.R. §§ 2.12(c)(5) – (6); 42 C.F.R. §§ 2.13(c)(1-2).]</i></p>	<p>Mental/Behavioral health information may be shared with law enforcement as required by law.</p> <p><i>[45 C.F.R. § 164.512(a), and (f).]</i></p>	<p>Behavioral health information may be shared with law enforcement as required by law.</p> <p><i>[CA Civ. Code § 56.30.]</i></p>

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<p><i>Payment and Determination of Benefits</i></p> <p>In support of a claim for payment, or application for services (including Qualified Service Organizations)</p>	<p>Mental health information necessary to make a claim for aid, insurance or medical assistance may be disclosed.</p> <p><i>[CA Welf. & Inst. § 5328(c).]</i></p>	<p>The records can be disclosed to qualified personnel when needed to provide services to the program for payment and determination of benefits including a Qualified Service Organization.</p> <p><i>[42 C.F.R. § 2.11, § 2.12(c)(4), and § 2.12(d)(2).]</i></p>	<p>Mental/Behavioral health information may be used or disclosed, without a patient authorization, to facilitate payment and determination of benefits.</p> <p><i>[45 C.F.R § 164.506.]</i></p>	<p>Behavioral health information may be used or disclosed, without a patient authorization, to facilitate payment and determination of benefits.</p> <p><i>[CA Civ. Code § 56.10(c).]</i></p>

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<i>Behavioral Healthcare / Public Health Policy</i> For research	<p>Mental health information may be disclosed, as provided for in regulations adopted by the California Departments of Health Care Services, State Hospitals, Social Services or Developmental Services, specifying rules and necessary approvals for the conduct of research, and specifying confidentiality requirements for researchers (including all researchers sign an oath of confidentiality). [CA Welf. & Inst. § 5328(e), and § 5329.]</p>	<p>The records can be disclosed to qualified personnel for scientific research, management audits, financial and compliance audits or program evaluation, as long as any report on such activities does not identify patient identities in any way. [42 C.F.R. § 2.1(b)(2)(B), § 2.2(b)(2)(B), § 2.52, and § 2.53; CA Health & Saf. § 11845.5(c)(3).]</p>	<p>Mental/Behavioral health information may be used or disclosed for research as a limited data set that excludes direct identifiers, if the covered entity enters into a data use agreement with the limited data set recipient. [45 C.F.R. § 164.514(e).]</p>	<p>Mental/Behavioral health information may be shared for bona fide research purposes. However, no information may be further disclosed by the recipient in a way that would disclose the identity of a patient. [CA Civ. Code § 56.10(c)(7).]</p>

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<i>Treatment / Coordination of Care</i> For medical emergency	Mental health information may be shared for diagnosis and treatment. <i>[CA Welf. & Inst. § 5328(a).]</i>	Substance use disorder information may be disclosed about a patient for the purpose of treating a medical emergency. <i>[42 C.F.R. § 2.51; CA Health & Saf. § 11845.5(c)(2).]</i>	Mental/Behavioral health information may be used or disclosed, without a patient authorization, to facilitate treatment. <i>[45 C.F.R. § 164.506(c) (4).]</i>	Behavioral health information may be used or disclosed, without a patient authorization, to facilitate treatment. <i>[CA Civ. Code § 56.10(c)(1).]</i>

Category/ Purpose	Mental Health Regulated by CA Welfare and Institutions Code (LPS)	Substance Use Disorder Regulated by 42 C.F.R. Part 2 and CA Health and Safety Code	Mental/Behavioral Health Regulated by 45 C.F.R. (HIPAA)	Mental/Behavioral Health Regulated by CA Civil Code (CMIA) and CA Health and Safety Code
<i>Treatment / Coordination of Care</i> Treatment (not medical emergency)	Qualified professional persons having responsibility for the patient's care whether internal or external to the facility may share the patient's mental health information to provide treatment or referral for treatment. <i>[CA Welf. & Inst. § 5328(a).]</i>	Substance use disorder information can be disclosed to qualified personnel when needed for treatment, within a program. Communications between a program and an entity that has direct administrative control of the program for treatment may occur without authorization. <i>[42 C.F.R. § 2.12(c)(3), and §2.12(d)(2); CA Health & Saf. §11845.5(c)(1).]</i>	Mental/Behavioral health information may be used or disclosed, without a patient authorization, to facilitate treatment. <i>[45 C.F.R § 164.506.]</i>	Mental/Behavioral health information may be used or disclosed, without a patient authorization, to facilitate treatment. <i>[CA Civ. Code §56.10.]</i>

Guidance for Specific Scenarios

Treatment and Coordination of Care

Care coordination involves planning and organizing a patient's [treatment](#) activities and sharing health information with others responsible for a patient's care to achieve improved health outcomes and more effective care. To effectively integrate and coordinate treatment and other care, patient information must be securely and appropriately shared by and between [healthcare providers](#), (e.g., physical health providers, substance use disorder (SUD) providers, mental health providers) as well as various delivery systems (e.g. Federally Qualified Health Centers, county mental health programs). [Protected health information \(PHI\)](#) can generally be shared for treatment and diagnosis purposes. The extent that behavioral health information can be shared for treatment and [coordination of care](#) is regulated by the Health Insurance Portability and Accountability Act (HIPAA), the California Medical Information Act (CMIA), the Lanterman-Petris-Short (LPS) Act and 42 C.F.R. Part 2 – Confidentiality of Substance Use Disorder Patient Records.

Scenario 1 - Behavioral Health to Physical Health

Description

To provide effective [treatment](#) and coordinated care, a physical health provider needs patient health information from a behavioral healthcare provider, such as substance use disorder (SUD) treatment information or [mental health information](#).

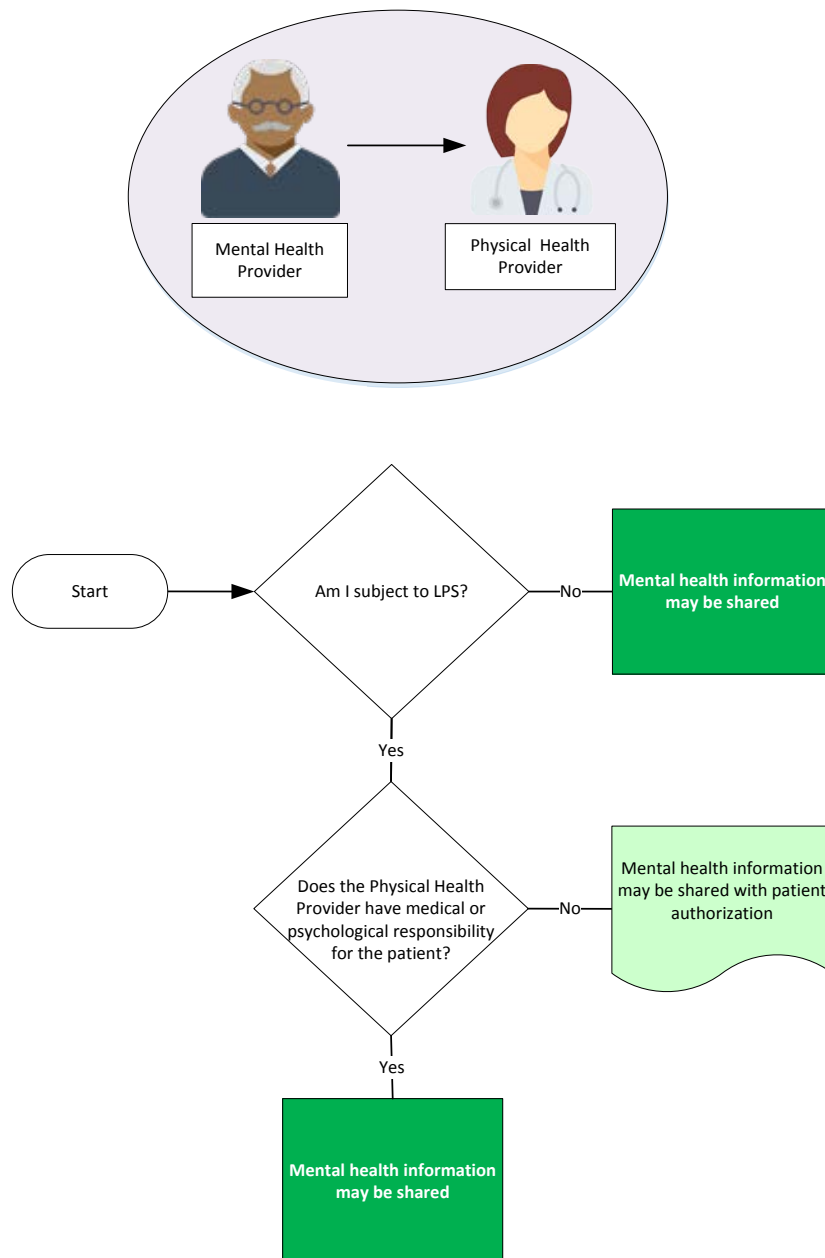
What patient health information can a behavioral health provider share with a physical health provider to provide treatment to the patient?

Graphic - Behavioral Health to Physical Health

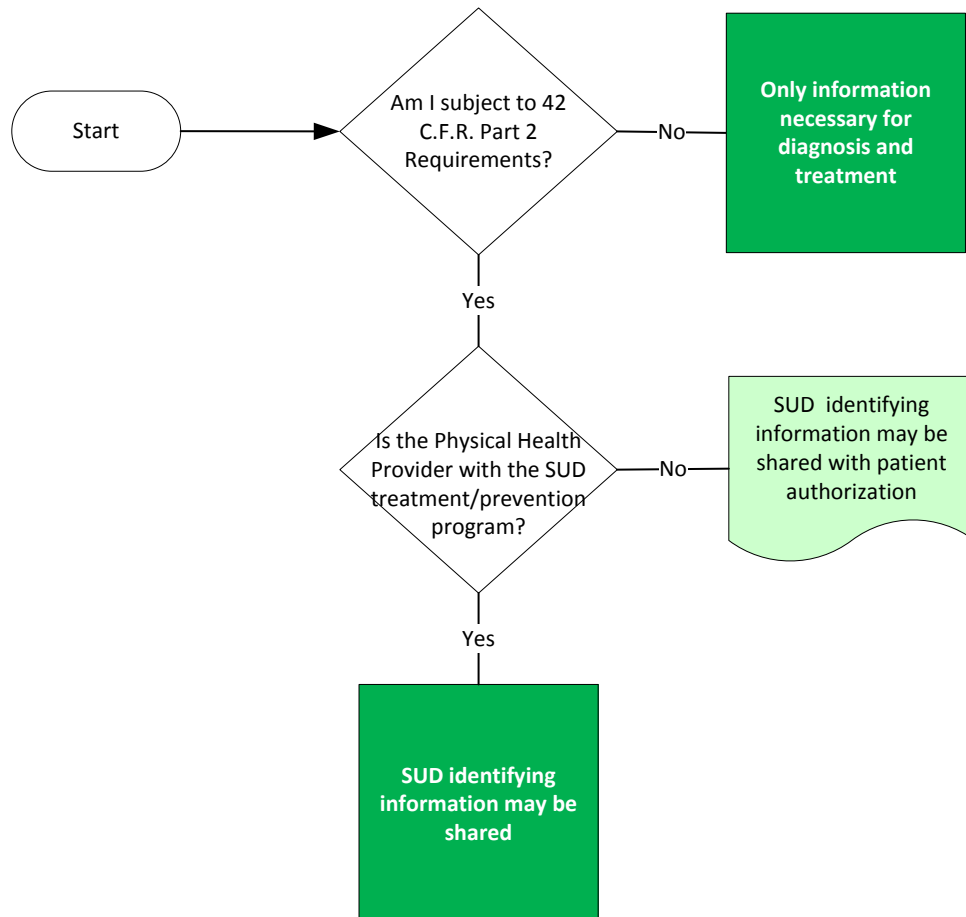
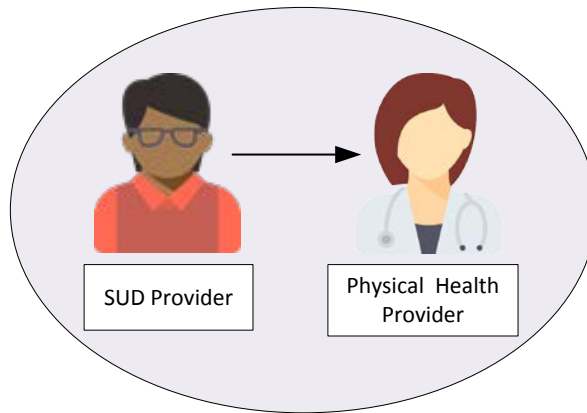
Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no medical emergency
- There is no court order

Mental Health



Substance Use Disorder



Scenario Guidance - Behavioral Health to Physical Health

Protected health information (PHI) can generally be shared for treatment and diagnosis purposes. PHI includes mental health, SUD and general medical information. The extent to which sharing of mental health and SUD information is permitted depends on whether the provider is regulated by 42 C.F.R. Part 2 (SUD) and therefore subject to stronger restrictions. The mental health provider may share Lanterman-Petris-Short (LPS) regulated patient information with any **healthcare provider** (any discipline) “who has medical or psychological responsibility for the patient.” The SUD provider (e.g., providers subject to 42 C.F.R Part 2 regulations) may only share within the SUD facility/treatment program or with a **qualified service organization (QSO)** providing services to the SUD facility or program.

[CA Welf. & Inst. § 5328(a); CA Civ. Code § 56.10(c)(2); CA Health & Saf. § 11845.5(c); 45 C.F.R. 164.506.]

A mental health provider may **disclose** LPS-regulated **mental health information** with physical health providers without a patient authorization as long as the provider has responsibility for the patient’s medical or psychiatric care. The information may include prescribed psychotropic medications, diagnosis and treatment information, and programs/services utilized (discharge plans for the **primary care provider**). If the physical health provider does not have medical or psychiatric responsibilities for the patient, LPS protected health information can only be shared with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(a-c); CA Civ. Code § 56.10(c)(1); 45 C.F.R. § 164.501.]

A SUD provider subject to 42 C.F.R Part 2 regulations may disclose patient demographics, diagnosis, prognosis and treatment information without authorization provided one of the following conditions is met:

- The physical health provider is a treatment/prevention program professional *in the same facility/treatment program*
- The physical health provider is employed by a QSO that provides services to the **SUD treatment program**
- The patient’s health information is needed to respond to an immediate threat to the health of the individual (see **Scenario 8 - In the Event of Emergency**)

[CA Welf. & Inst. § 5328(a-c); CA Health & Saf. § 11845.5(c)(1); 42 C.F.R. § 2.12(c)(4); 42 C.F.R. § 2.51(a); 45 C.F.R. § 164.502(b); CA Civ. Code § 56.10.]

If none of the above conditions is met, SUD protected health information can only be shared with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(a-c); 42 C.F.R. § 2.31.]

Citations and Related Guidance

- 42 C.F.R. § 2.12(c).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 2.51(a).
- 45 C.F.R. §164.501.
- 45 C.F.R. § 164.502(b).
- 45 C.F.R. 164.506.
- CA Civ. Code § 56.10.
- CA Health & Saf. § 11845.5(c)(1).
- CA Welf. & Inst. § 5328 (a-c).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 2 - Physical Health to Behavioral Health

Description

To provide effective [treatment](#) and coordinated care, a behavioral healthcare provider needs patient information from a physical health provider, such as prescribed medications, known allergies, mental health or [substance use disorder \(SUD\) patient-identifying information](#).

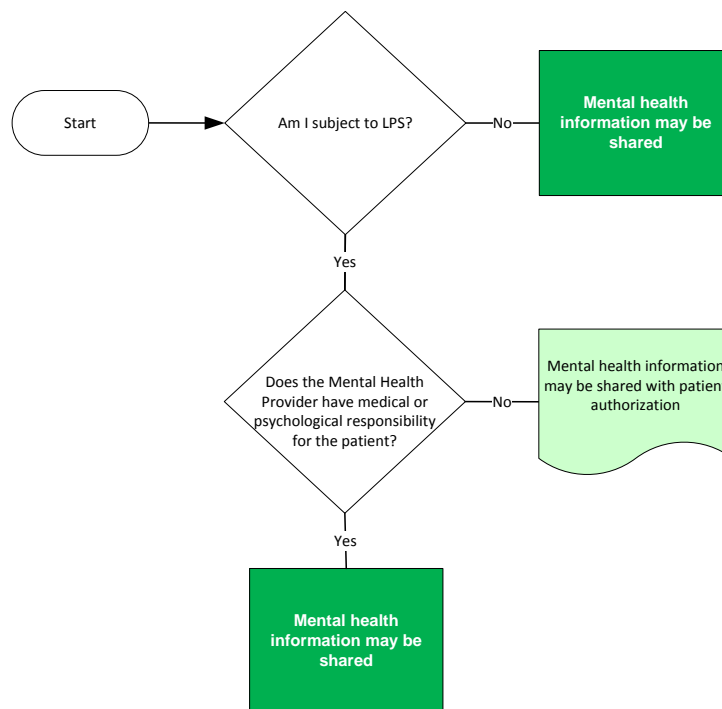
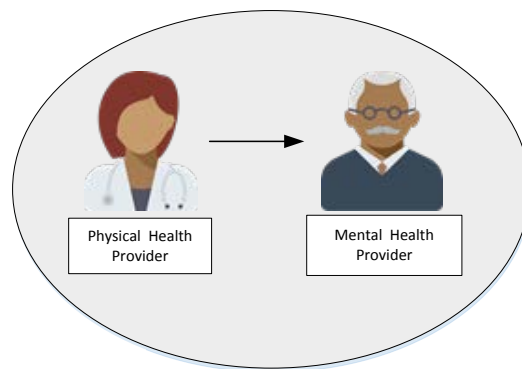
What patient health information can a physical health provider share with a behavioral health provider to provide treatment to the patient?

Graphic - Physical Health to Behavioral Health

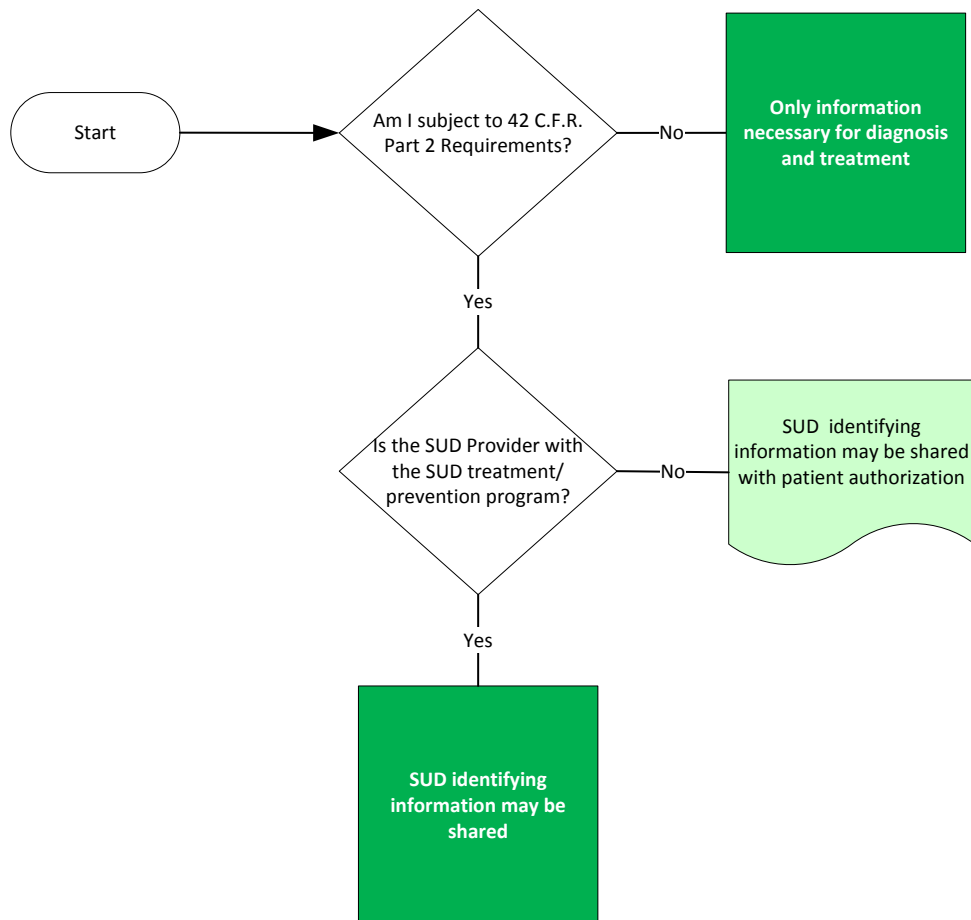
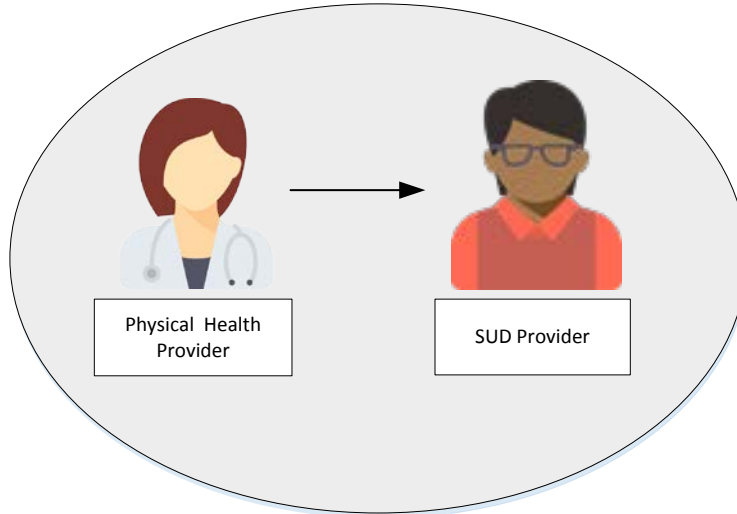
Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no medical emergency
- There is no court order

Mental Health



Substance Use Disorder



Scenario Guidance - Physical Health to Behavioral Health

[Protected Health Information \(PHI\)](#) can generally be shared for treatment and diagnosis purposes. PHI includes mental health, SUD, and general medical information. The physical health provider may share Lanterman-Petris-Short (LPS) regulated patient information with a [healthcare provider](#) in any discipline who has “medical or psychological responsibility for the patient.” The extent to which sharing of mental health and SUD information is permitted, however, depends on whether the provider is regulated by 42 C.F.R. Part 2. SUD patient-identifying information protected by 42 C.F.R. Part 2 is subject to stronger restrictions.

[CA Welf. & Inst. § 5328(a); CA Civ. Code § 56.10; Health & Saf. § 11845.5(c); 42 C.F.R. § 2.51(a); 45 C.F.R. § 164.506.]

In general, a physical health provider may [disclose](#) LPS-regulated [mental health information](#) without a patient authorization with a behavioral healthcare provider who has responsibility for the patient’s mental or behavioral healthcare. The information may include prescribed psychotropic medications, diagnosis and treatment information, and programs/services utilized if relevant to treatment. If the mental health provider for some reason does not have medical or psychiatric responsibilities for the patient, LPS protected health information can only be shared with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(a-b); 45 C.F.R. § 164.501.]

A physical health provider subject to 42 C.F.R Part 2 regulations may disclose patient demographics, diagnosis, prognosis and treatment information without authorization provided one of the following conditions is met:

- The SUD health provider is a treatment/prevention program professional *in the same facility/treatment program*
- The SUD health provider is employed by a QSO that provides services to the [SUD treatment program](#)
- The patient’s health information is needed to respond to an immediate threat to the health of the individual (see [Scenario 8 - In the Event of Emergency](#))

[CA Health & Saf. § 11845.5(c)(1); 42 C.F.R. § 2.12(c)(4); 42 C.F.R. § 2.51(a); 45 C.F.R. § 164.502(b); CA Civ. Code § 56.10.]

If none of the above conditions is met, SUD protected health information can only be shared with a valid patient or patient representative authorization.

[42 C.F.R. § 2.31.]

Citations and Related Guidance

- 42 C.F.R. § 2.12(a)(1).
- 42 C.F.R. § 2.12(c)(4).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 2.51(a).
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.502(b).
- 45 C.F.R. § 164.506.
- CA Civ. Code § 56.10.
- CA Health & Saf. § 11845.5(c)(1).
- CA Welf. & Inst. § 5328 (a-b).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 3 - Behavioral Health to Other Behavioral Health

Description

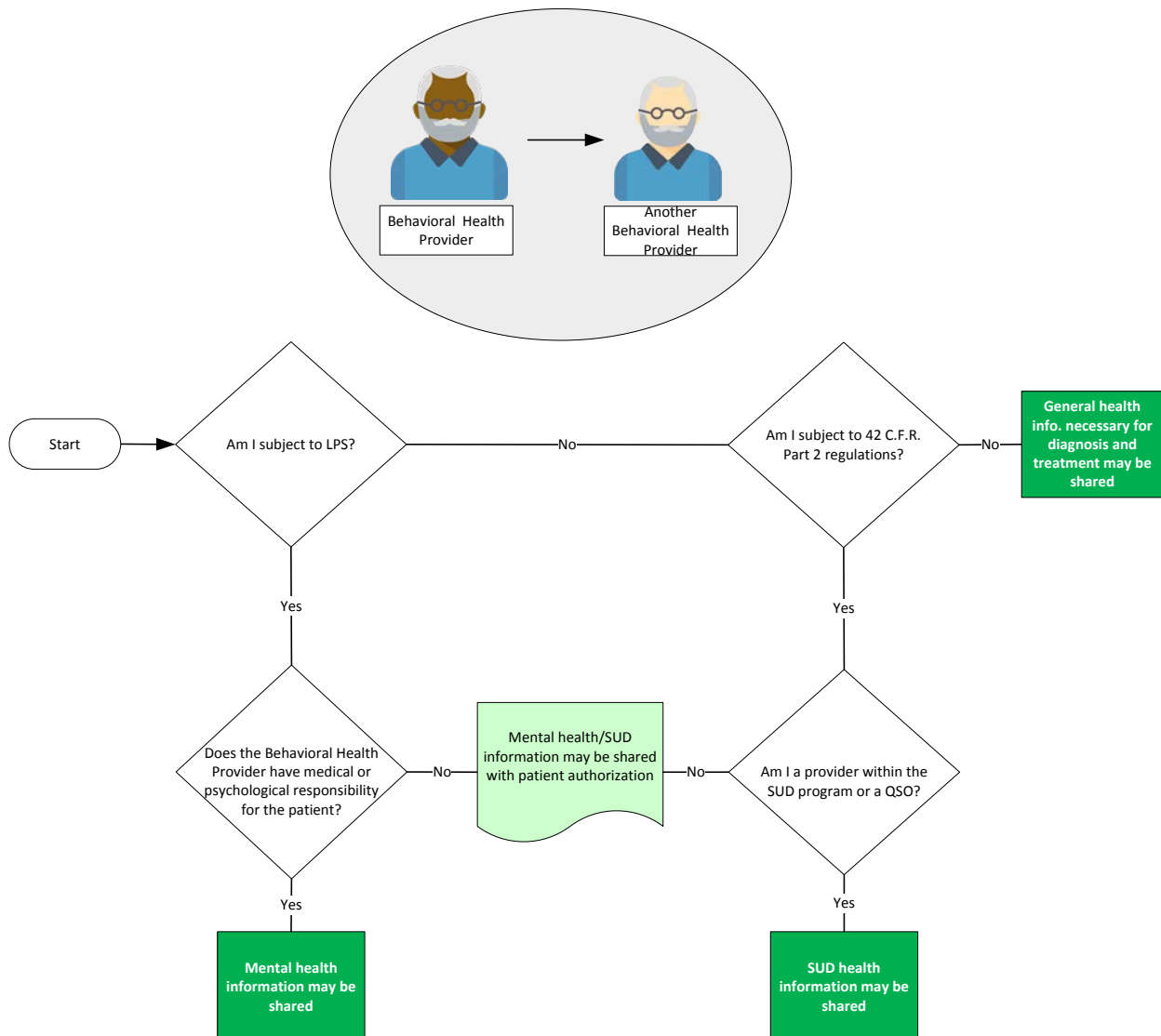
A behavioral healthcare provider needs patient information from a hospital to transition a patient to appropriate behavioral healthcare providers upon discharge. Health information may include mental health or [substance use disorder \(SUD\) patient-identifying information](#).

What patient health information can a behavioral health provider share with another behavioral health provider for transition and discharge planning?

Graphic - Behavioral Health to Other Behavioral Health

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no medical emergency
- There is no court order



Scenario Guidance – Behavioral Health to Other Behavioral Health

Protected health information (PHI) can generally be shared for treatment and diagnosis purposes. PHI includes mental health, SUD, and general medical information. The extent to which sharing of patient mental health and SUD information is permitted, however, depends on whether the provider is regulated by 42 C.F.R. Part 2. SUD patient-identifying information protected by 42 C.F.R. Part 2 is subject to stronger restrictions.

[CA Welf. & Inst. § 5328(a) and (c); CA Civ. Code § 56.10(c); 42 C.F.R. § 2.12(a)(1).]

Recognizing the importance of effective follow-up care, the State of California requires a written aftercare plan upon a patient's discharge from most inpatient mental health treatment. A mental health provider may disclose mental health information with another behavioral healthcare provider without a patient authorization as long as each provider has responsibility for the patient's psychiatric care. The information may include prescribed psychotropic medications, diagnosis and treatment information, and programs/services utilized (discharge plans for the primary care provider). If the other behavioral health provider for some reason does not have medical or psychiatric responsibilities for the patient, LPS protected health information can only be shared with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(a-b); CA Welf. & Inst. § 5622; CA Welf. & Inst. § 5768.5; CA Health & Saf. Code § 1262; 45 C.F.R. § 164.501.]

A SUD provider subject to 42 C.F.R. Part 2 regulations may disclose patient demographics, diagnosis, prognosis and treatment information without authorization provided one of the following conditions is met:

- The other behavioral health provider is a treatment/prevention program professional *in the same facility/treatment program*
- The other behavioral health provider is employed by a QSO that provides services to the SUD treatment program
- The patient's health information is needed to respond to an immediate threat to the health of the individual (see Scenario 8 - In the Event of Emergency)

[CA Health & Saf. § 11845.5(c)(1); 42 C.F.R. § 2.12(c)(3) and (4); 42 C.F.R. § 2.51(a); 45 C.F.R. § 164.502(b); CA Civ. Code § 56.10.]

If none of the above conditions is met, SUD protected health information can only be shared with a valid patient or patient representative authorization.

[42 C.F.R. § 2.31]

Citations and Related Guidance

- 42 C.F.R. § 2.12(a)(1).
- 42 C.F.R. § 2.12(c)(3).
- 42 C.F.R. § 2.12(c)(4).
- 42 C.F.R. § 2.51(a).
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.502(b).
- CA Civ. Code § 56.10.
- CA Health & Saf. Code § 1262.
- CA Health & Saf. § 11845.5(c)(1).
- CA Welf. & Inst. § 5328(a-c).
- CA Welf. & Inst. § 5622.
- CA Welf. & Inst. § 5768.5.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 4 - Behavioral Health to Social Services

Description

Social services organizations often serve individuals with mental health or substance use disorder (SUD) issues. For example, to locate supportive housing in proximity to their client's healthcare [access](#) needs, a social services case manager (SSCM) may need a behavioral healthcare provider to share patient behavioral health information.

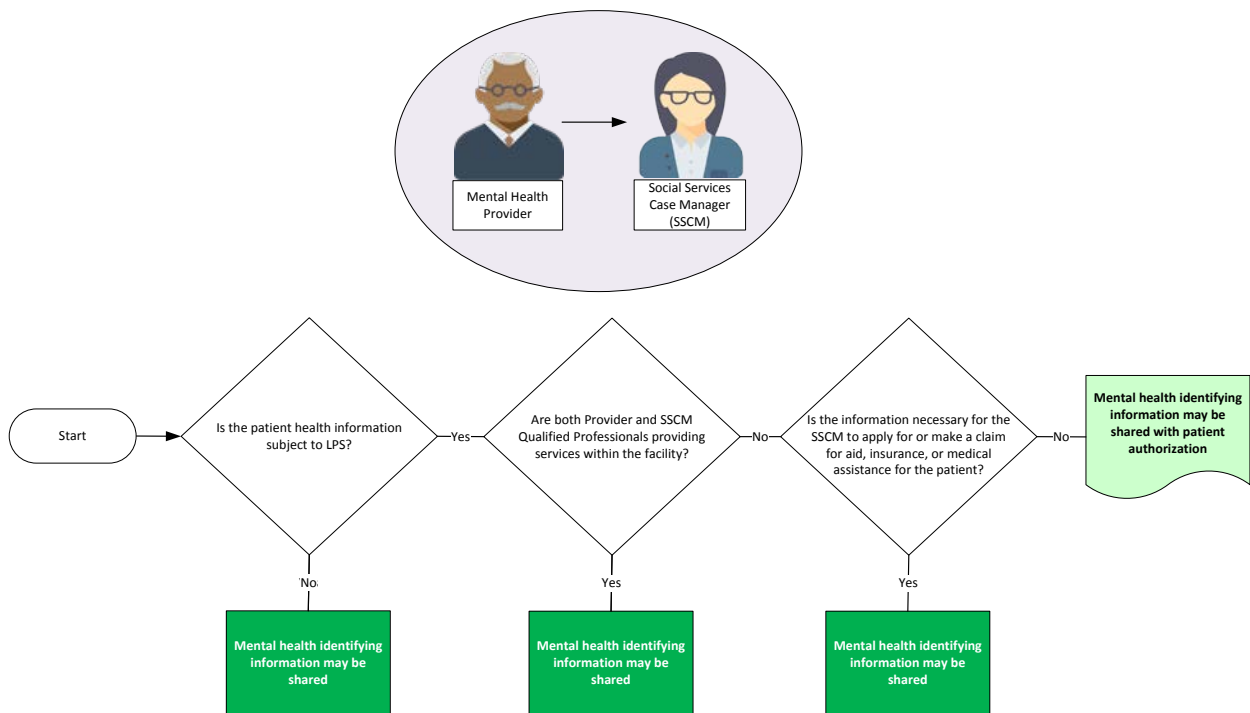
What patient health information can a behavioral health provider share with the social services case manager?

Graphic - Behavioral Health to Social Services

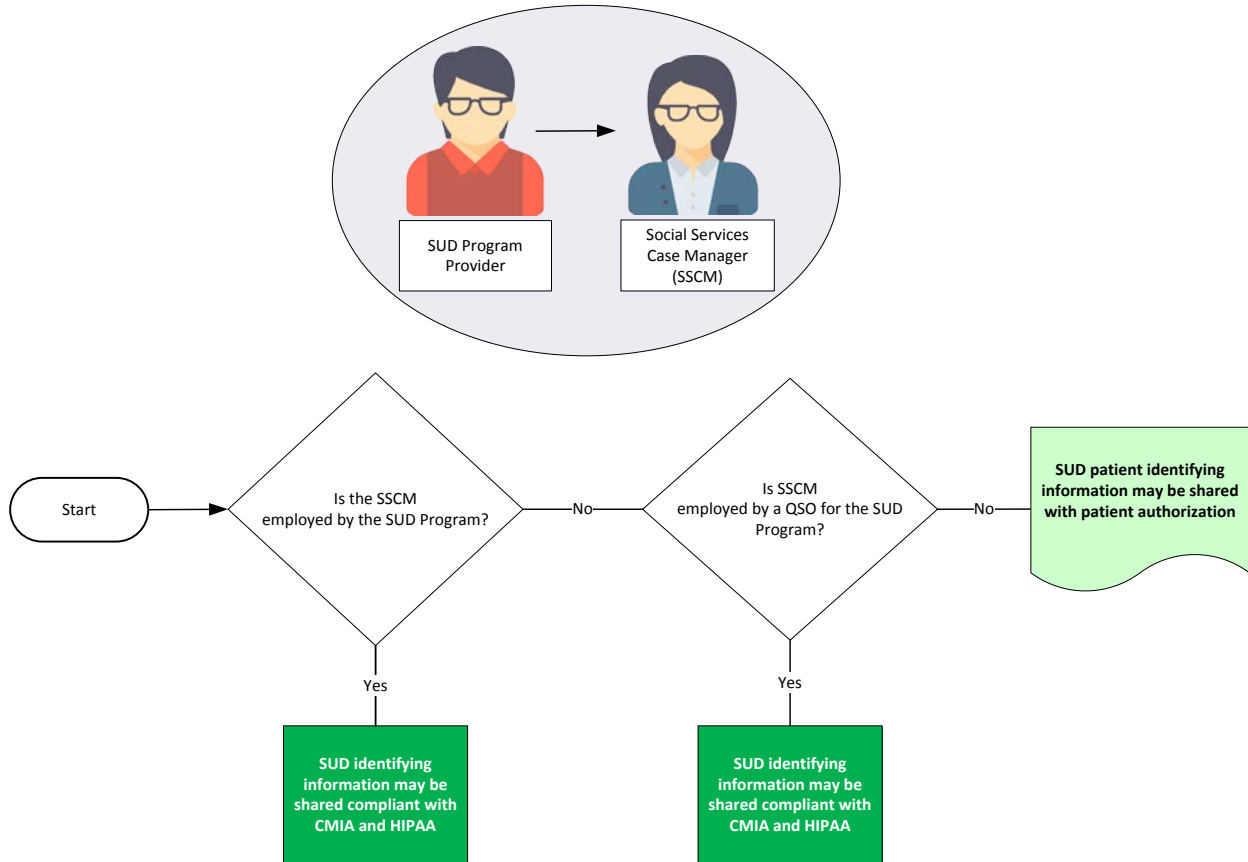
Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no medical emergency
- There is no court order

Mental Health



Substance Use Disorder



Scenario Guidance - Behavioral Health to Social Services

For purposes of applying for or making a claim for medical assistance or benefits on behalf of a patient, the law varies depending on whether the behavioral health information is regulated by the Lanterman–Petris–Short (LPS) Act (mental health), 42 C.F.R. Part 2 (SUD), the Health Insurance Portability and Accountability Act (HIPAA), and/or the Confidentiality of Medical Information Act (CMIA). If the purpose of sharing behavioral health information with a SSCM is specifically to make a claim for medical assistance or benefits on behalf of the patient, the [protected health information \(PHI\)](#) may be shared under the conditions described in the following paragraphs.

A mental health provider may [disclose](#) patient health information to a SSCM if any of the following criteria is met:

- The patient health information is regulated by CMIA and HIPAA. The SSCM may receive mental health information to make a claim for medical assistance or benefits on behalf of the patient.
[CA Civ. Code § 56.10; 45 C.F.R. § 164.506.]
- The SSCM receiving the information and [person](#) providing the information are [qualified professional persons](#) providing services within the [treatment](#) facility.
[CA Welf. & Inst. § 5328(a).]
- The [mental health information](#) is necessary to make a claim or application for aid, insurance, or medical assistance on the patient’s behalf.
[CA Welf. & Inst. § 5328(c).]

If none of the above criteria is met, the mental health information can be shared with a SSCM only with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(b).]

[Substance use disorder \(SUD\) patient-identifying information](#) is highly sensitive and specially protected under federal law. Without patient authorization, disclosure is strictly regulated for any patient information that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a [SUD treatment program](#) that receives federal assistance. Since federal assistance is broadly defined in regulations and includes Medicare and Medicaid [payments](#), a significant percentage of SUD patient-identifying information falls under the strict federal regulations, often referred to as “Part 2” regulations.

Despite the restrictions, a SUD provider may disclose information that would identify the individual as a past or present SUD patient to a SSCM without a patient authorization if either of the following criteria are met:

- The SSCM is employed by the program (or an organization with direct administrative control of the program) to provide diagnosis, treatment or referral for treatment for the program's patients. Treatment means the management and care of a SUD patient in order to reduce or eliminate the adverse effects of SUD on the patient, which may include care coordination after inpatient services. As long as the SUD patient-identifying information is shared within the program or between the program and an organization with administrative control of the program, the sharing of information is internal and therefore allowed.

[42 C.F.R. § 2.12(c)(3).]

- The SSCM is employed by a [qualified service organization \(QSO\)](#) to determine patient benefit eligibility, arrange for medical assistance, or directly provide follow-up care to the program's SUD patient. The QSO must have an appropriate written agreement in effect with the program as defined in the 42 C.F.R. Part 2 regulations. A QSO may not re-disclose SUD patient-identifying information without written authorization.

[42 C.F.R. § 2.12(c)(4); 42 C.F.R. § 2.11; 42 C.F.R. § 2.32.]

If neither of the above conditions is met, the SUD patient-identifying information can be shared with a SSCM only with a valid SUD patient authorization.

[42 C.F.R. § 2.31.]

Citations and Related Guidance

- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(c)(3-4).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 2.32.
- 45 C.F.R. § 164.506
- CA Civ. Code § 56.10
- CA Health & Saf. § 11845.5(c)(1).
- CA Welf. & Inst. § 5328(a-c).
- CA Welf. & Inst. § 5328.6.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 5 - Mental Health Provider to Caregiver or Care Coordinator

Description

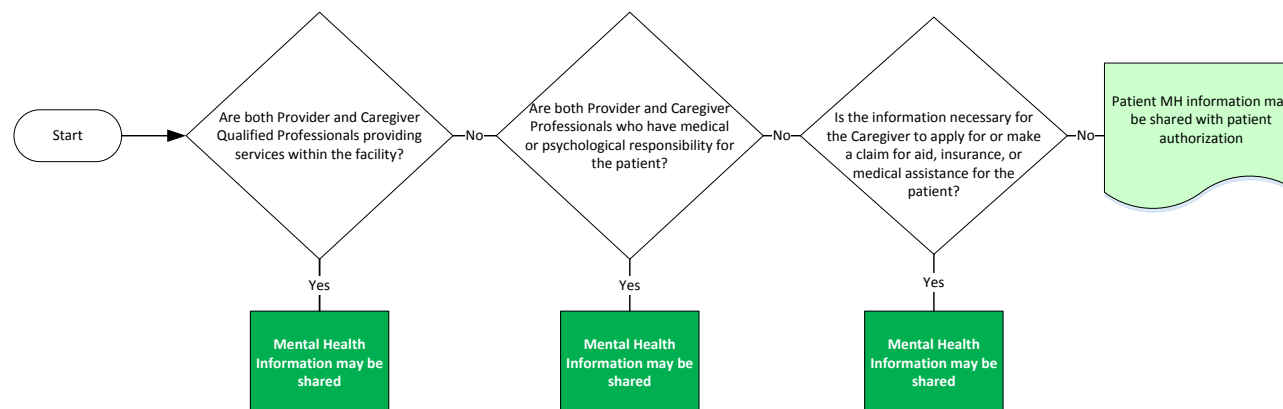
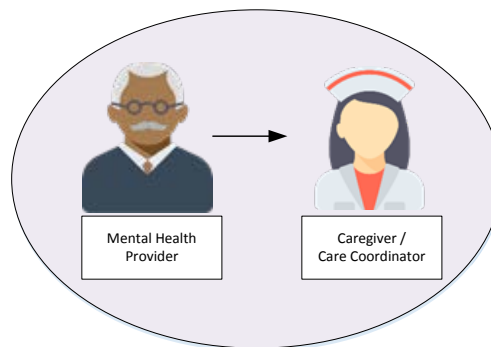
A mental health provider wants to share a patient's mental health information with an individual to determine benefit eligibility for support services, arrange medical assistance for, or directly provide follow-up care to the patient outside of the provider's outpatient or inpatient facility. Such information might include direction regarding follow-up care instructions, medications, in-home care guidelines and related patient care services.

What patient health information can a mental health provider share with a person who has caregiver responsibilities?

Graphic - Mental Health Provider to Caregiver or Care Coordinator

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- The patient information mental health information is regulated by LPS



Scenario Guidance – Mental Health Provider to Caregiver or Care Coordinator

Mental health information is sensitive. In most circumstances, in California [mental health information](#) may only be shared with the authorization of the patient or patient representative.

Recognizing the importance of effective follow-up care, the State of California requires a written aftercare plan upon a patient's discharge from most inpatient mental health treatment. A variety of individuals may be involved as caregivers to help with the aftercare. The Health Insurance Portability and Accountability Act (HIPAA) and California Medical Information Act (CMIA) permit sharing without an authorization of some [protected health information \(PHI\)](#) with family members and other individuals when directly relevant to the individual's involvement with the patient's healthcare (or payment related to the patient's healthcare), but these types of disclosures require an authorization for mental health information under the Lanterman-Petris-Short (LPS) statutes.

[CA Welf. & Inst. § 5328.1(a-b); CA Welf. & Inst. § 5622; CA Welf. & Inst. § 5768.5; CA Health & Saf. Code § 1262; 45 C.F.R. § 164.510(b)(1)(i); CA Civ. Code § 56.1007.]

Despite the LPS restrictions, mental health information may be shared without authorization with a caregiver arranging medical assistance for, or directly providing care to, the patient if any of the following conditions are met:

- The caregiver or care coordinator receiving the information and [person](#) providing the information are [qualified professional persons](#) (e.g., physician, licensed psychologist, licensed professional clinical counselor, non-clinician professionals) providing services within the [treatment](#) facility.

[CA Welf. & Inst. § 5328(a).]

- The caregiver or care coordinator receiving the information and person providing the information are professionals providing medical or psychological treatment to the patient. The professionals providing treatment do not have to be within the same facility.

[CA Welf. & Inst. § 5328(a).]

- The mental health information is necessary to make a claim or application for aid, insurance, or medical assistance on the patient's behalf.

[CA Welf. & Inst. § 5328(c).]

If none of the above conditions is met, the mental health information regulated by LPS can be shared with a caregiver/care coordinator only with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(b).]

Citations and Related Guidance

- 45 C.F.R. § 164.506.
- 45 C.F.R. § 164.510(b)(1)(i).
- CA Civ. Code § 56.1007.
- CA Health & Saf. Code § 1262.
- CA Welf. & Inst. § 5328(a-c).
- CA Welf. & Inst. § 5328.1(a-b).
- CA Welf. & Inst. § 5622.
- CA Welf. & Inst. § 5768.5.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 6 - Substance Use Disorder Provider to Caregiver

Description

A substance use disorder (SUD) health provider wants to share a patient's substance use health information with an individual determining benefit eligibility for support services, arranging medical assistance for, or directly providing follow-up care to the patient outside of the provider's office or facility. Such information might include general direction regarding follow-up care instructions, medications, in-home care guidelines and related patient care services.

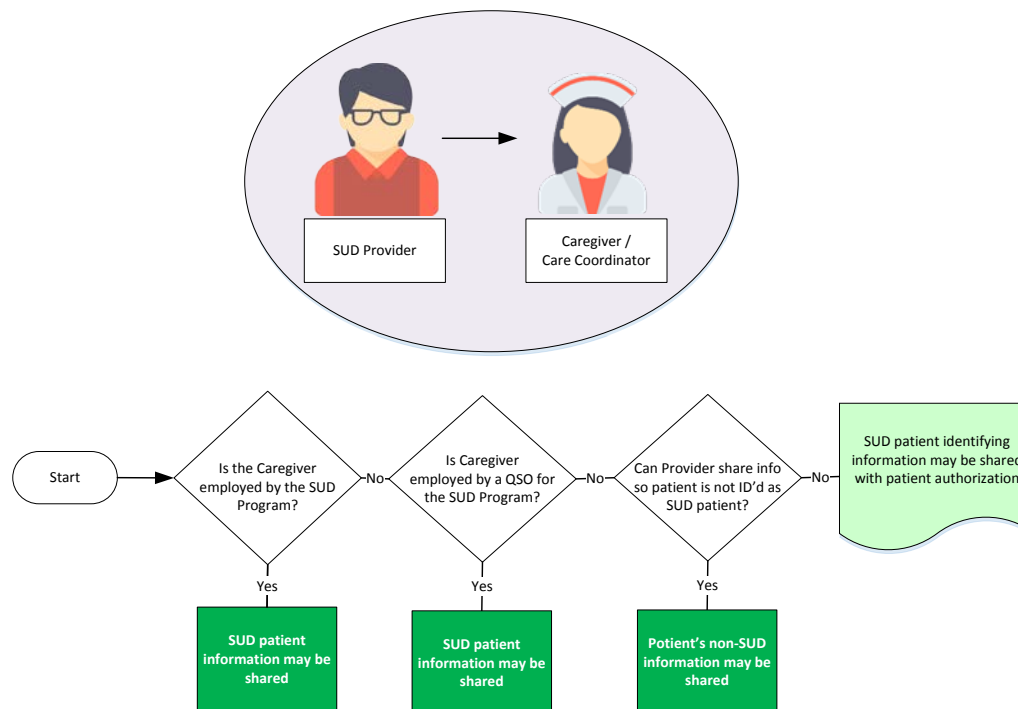
What patient health information can a substance use disorder provider share with a person who has caregiver or care coordinator responsibilities?

Graphic - Substance Use Disorder Provider to Caregiver or Care Coordinator

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order
- The SUD health provider is covered by 42 C.F.R. Part 2 regulations

Substance Use Disorder



Scenario Guidance - Substance Use Disorder Provider to Caregiver or Care Coordinator

Substance use disorder (SUD) patient-identifying information is highly sensitive. **Disclosure** without patient authorization of any patient information that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program, is strictly regulated for any federally-assisted **SUD treatment program**. Since federal assistance is broadly defined in regulations and includes Medicare and Medicaid **payments**, a significant percentage of SUD patient-identifying information falls under the strict federal regulations, often referred to as “Part 2” regulations.

HIPAA and CMIA permit sharing of **protected health information (PHI)** without an authorization with family members and other individuals when the PHI is directly relevant to the person's involvement with the individual's healthcare (or payment related to the individual's healthcare). Under 42 C.F.R. Part 2 regulations, however, these types of disclosures are not permissible for SUD patient information without an authorization.

[42 C.F.R. § 2.1(a-b); 45 C.F.R. § 164.510(b)(1)(i); CA Civ. Code § 56.1007.]

Despite the 42 C.F.R. Part 2 restrictions, a SUD provider may share information without a patient authorization with a person acting as a caregiver to arrange medical assistance for, or directly providing care to, the patient outside of the program provider's office or facility if any of the following conditions are met:

- The caregiver is employed by the program (or an organization with direct administrative control of the program) to provide diagnosis, **treatment** or referral for treatment for the program's patients. SUD treatment means the management and care of a SUD patient in order to reduce or eliminate the adverse effects of SUD on the patient, which may include care coordination after inpatient services. As long as the SUD patient-identifying information is shared within the program or between the program and an organization with administrative control of the program, the sharing of information is internal and therefore allowed.

[CA Health & Saf. § 11845.5(c); 42 C.F.R. § 2.12(c)(3).]

- The caregiver is employed by a **qualified service organization (QSO)** to provide support services benefit eligibility determination, arrange for medical assistance, or directly provide follow-up care to the program's SUD patient. The QSO must have an appropriate written agreement in effect with the program as defined in 42 C.F.R. Part 2 regulations. A QSO may not re-disclose SUD patient-identifying information without written authorization.

[42 C.F.R. § 2.12(c)(4); 42 C.F.R. § 2.32.]

- The program provider can share patient information in such a way that the caregiver/care coordinator can perform his or her responsibilities and the patient cannot be identified as an SUD patient directly, by reference to other publicly available information, or by verification as an SUD patient by another person.

[42 C.F.R. § 2.12(a)(1); 45 C.F.R. §§ 164.501 and 164.506.]

If none of the above conditions is met, the SUD patient-identifying information can be shared with a caregiver/care coordinator only with a valid SUD patient authorization.

[42 C.F.R. § 2.31.]

Citations and Related Guidance

- 42 C.F.R. § 2.1(a-b).
- 42 C.F.R. § 2.12(a)(1).
- 42 C.F.R. § 2.12(c)(3-4).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 2.32.
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.506.
- 45 C.F.R. § 164.510(b)(1)(i).
- CA Civ. Code § 56.1007.
- CA Health & Saf. § 11845.5(c).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 7 - To Improve Coordination of Care

Description

Many healthcare policy makers are increasingly interested in determining if improved coordination of care between physical health, behavioral health and social services providers results in better health outcomes. Such collaborative patient-centric care across multiple service providers often requires sharing protected behavioral health information in innovative ways for mental health and substance use disorder (SUD). To determine if better integration and coordination of care can lead to the desired outcomes, the State of California and the federal government have implemented several initiatives in the state that provide funding to programs piloting alternative approaches to complex care to help meet medical, behavioral and even socioeconomic needs.

Examples of initiatives exploring a more holistic approach include:

- **Whole Person Care (WPC) Pilots** – The initiative (authorized by the Medi-Cal⁸ 2020 Section 1115(a) Waiver) tests county-based approaches that coordinate physical health, behavioral health and social services for high-risk, high-utilizing Medi-Cal patients that receive help from multiple systems with poor outcomes. Some of the goals of the pilots are to improve care access and coordination, achieve better health outcomes for WPC populations, increase access to appropriate housing and support services, and reduce inappropriate emergency room and inpatient utilization.
- **Coordinated Care Initiative** – The demonstration project (currently authorized by the Medi-Cal 2020 Section 1115(a) Waiver) promotes coordinated care to seniors and disabled persons with Medicare and Medi-Cal eligibility through specialized managed care plans.
- **Health Homes Program** – The initiative (authorized by the Affordable Care Act) allows providers to integrate and coordinate all primary, acute, behavioral health, and long-term services and related support for high-risk patients with Medicaid who have chronic conditions.⁹

Given the ongoing and active interest in such programs focused on integration and coordination of care, this scenario presents WPC as an example of an initiative that encourages the disclosure and sharing of specially protected health information for the benefit of the

⁸ Medi-Cal is the State of California's Medicaid program.

⁹ See Medicaid.gov website for more information: <https://www.medicaid.gov/medicaid/ltss/health-homes/index.html>

patient. Legislation authorizing such initiatives vary widely, and some of the legal citations supporting this scenario are specific to WPC and do not apply to other initiatives.

Even within an authorized WPC Pilot program, patient authorizations are required to disclose mental health information or information that identifies an individual as a past or present SUD patient. The WPC statute, however, states an individual must agree to participate in the pilot to receive services and can opt out at any time. Since agreement of the patient is required to participate, a patient authorization consistent with the Lanterman-Petris-Short Act (LPS) and 42 C.F.R. Part 2 requirements to disclose information to other WPC participating entities can readily be incorporated into the WPC patient participation agreement process.

What patient health information can a mental health or SUD provider share with other WPC entities to improve coordination of care for the patient?

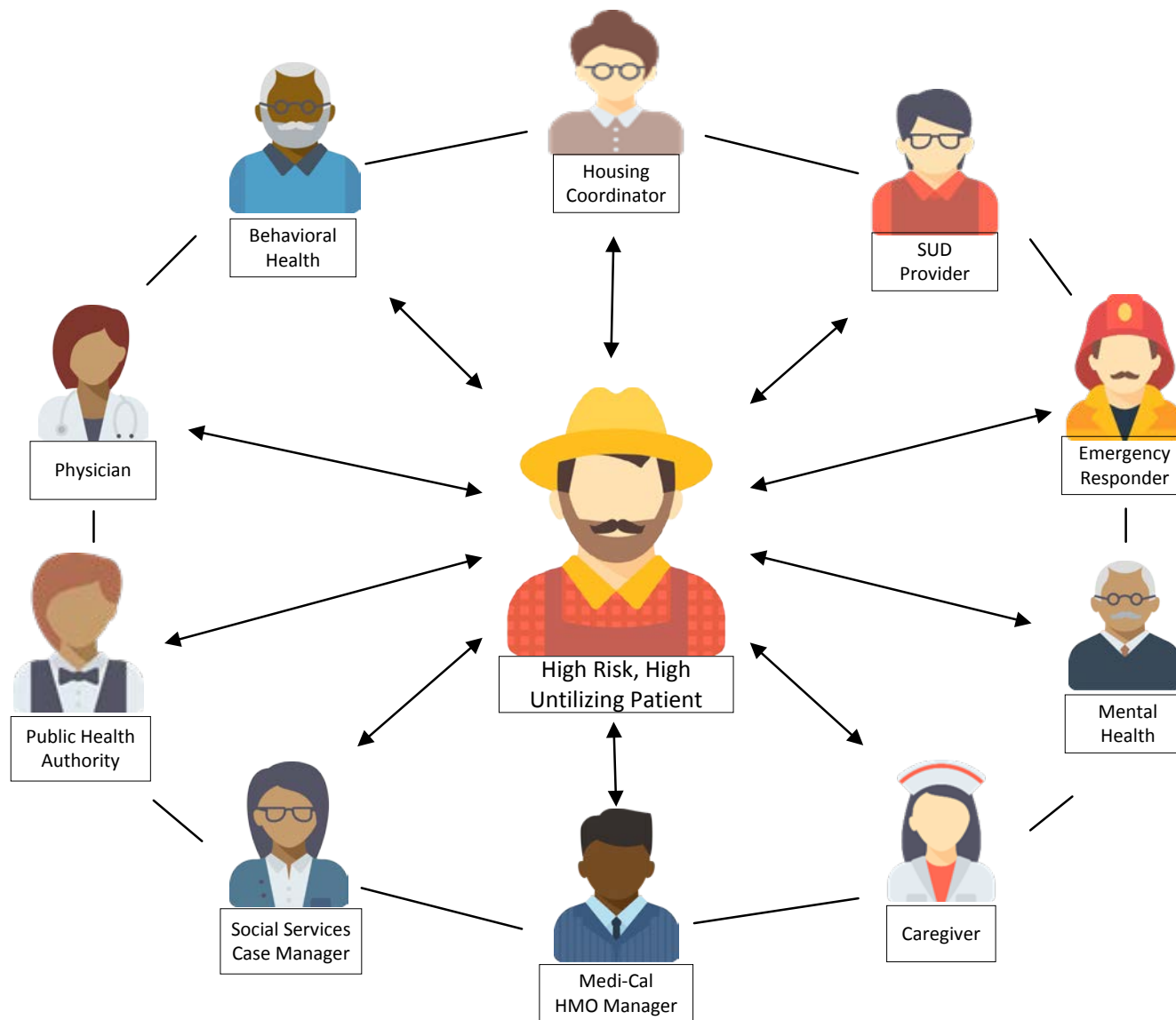
Graphic – To Improve Coordination of Care

Important Scenario Guidance Assumptions:

- The patient or [patient representative](#) has agreed to participate in a Whole Person Care pilot program and the agreement process includes patient authorization to use and disclose the specially protected patient information within the pilot's participating entities
- [Mental health information](#) for this scenario is regulated by the Lanterman-Petris-Short Act (LPS)
- [SUD patient-identifying information](#) for this scenario is regulated by 42 C.F.R. Part 2

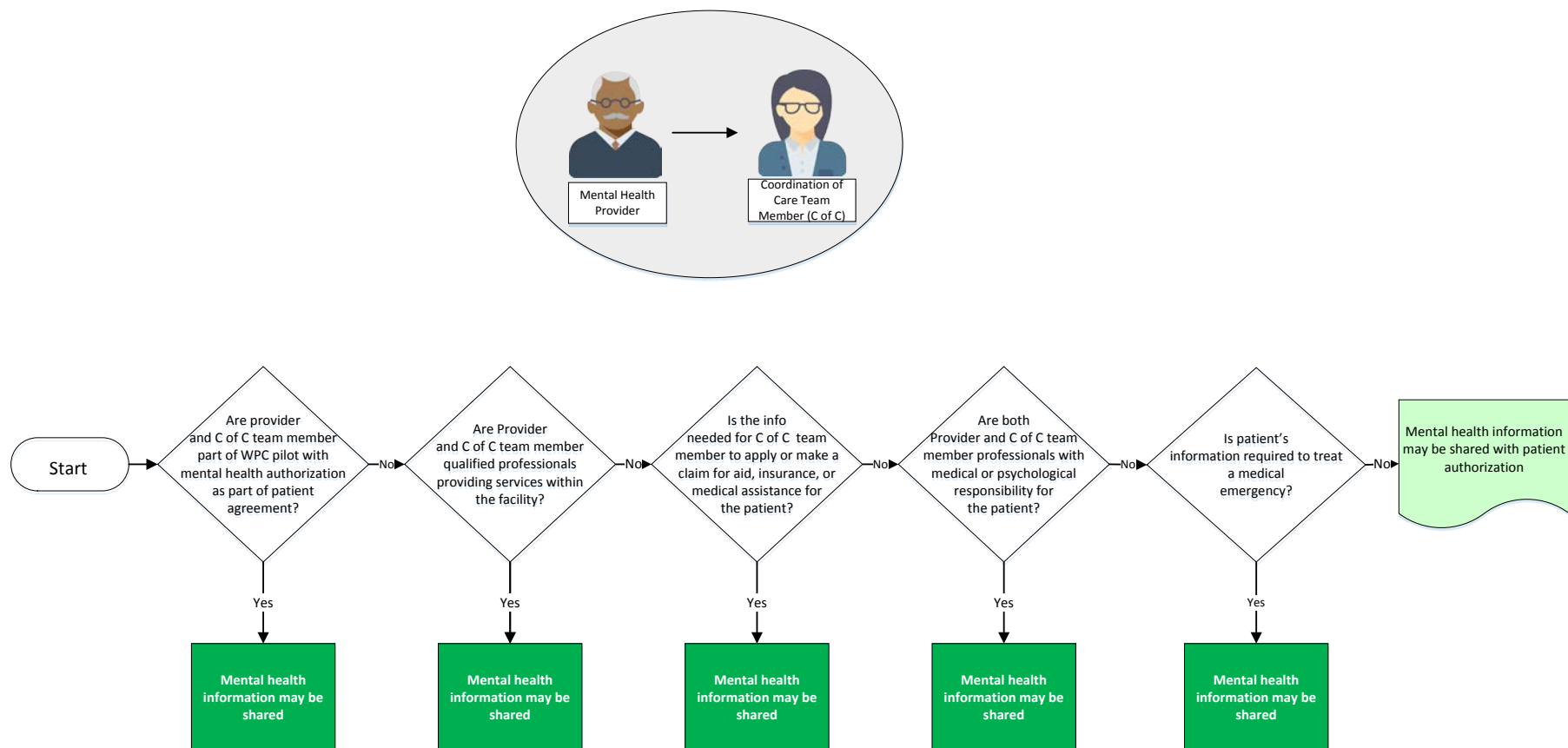
Whole Person Care Illustration

Note: WPC pilots focus on high-risk, high-utilizing Medi-Cal patients in specific geographic regions. Patient agreement to participate is required to receive pilot services. Participating providers/entities provide medical and non-medical services and participants vary by pilot.



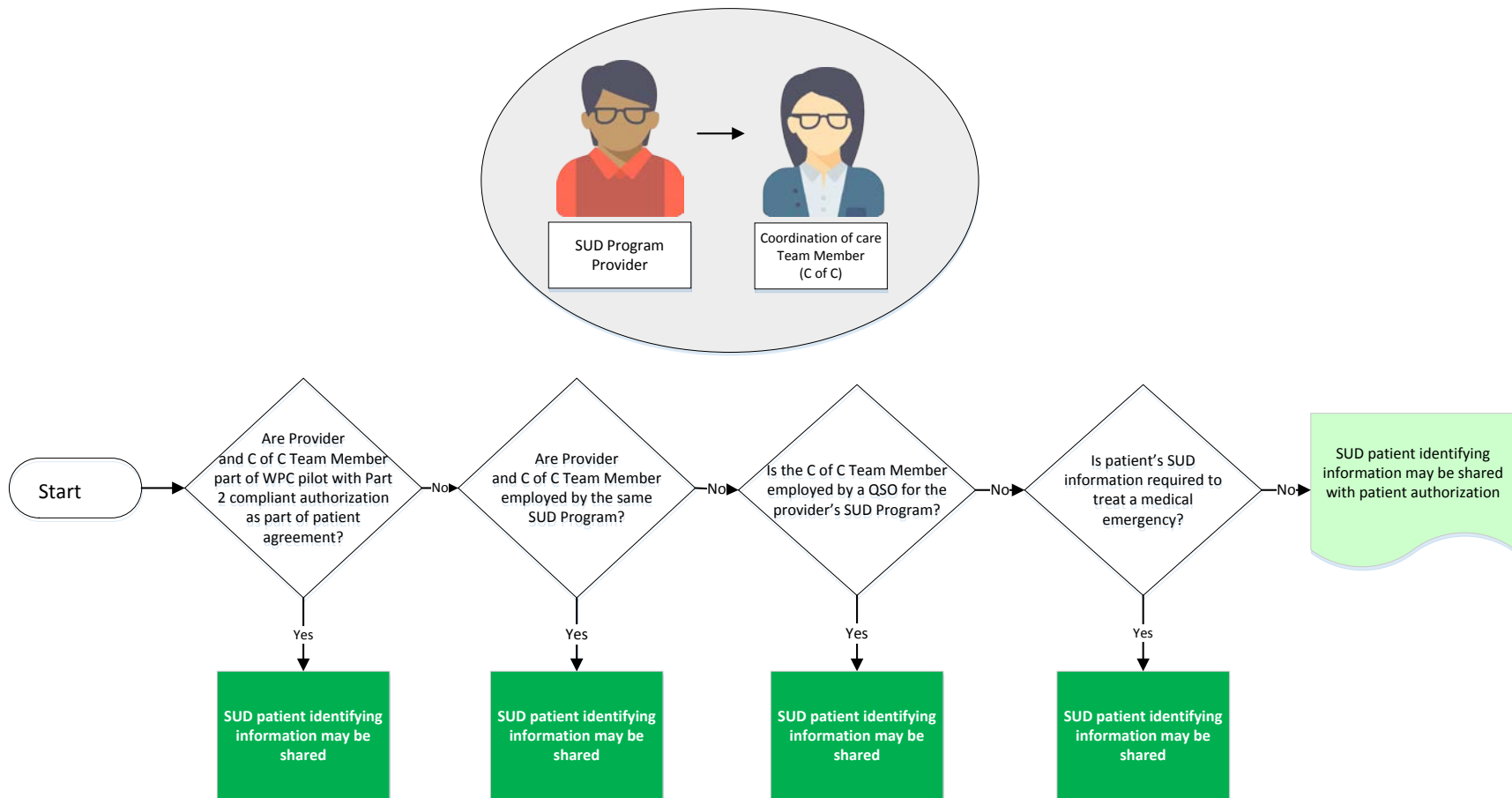
Mental Health

Note: For purposes of this scenario, mental health information is assumed to be information regulated by LPS.



Substance Use Disorder

Note: For purposes of this scenario, SUD patient-identifying information is assumed to be regulated by 42 C.F.R. Part 2.



Scenario Guidance – To Improve Coordination of Care

For purposes of integrating and coordinating care on behalf of a patient through an authorized Whole Person Care (WPC) pilot program, the statute authorizing WPC data-sharing requires the patient to agree to participate in the pilot with the ability to opt out at any time.

[CA Welf. & Inst. § 14184.60(a)(6).]

If the patient agreement includes authorization to use and disclose the patient’s mental health and SUD information within the pilot, such information may be shared within the WPC coordination of care team.

Mental health information may be shared between the participants of WPC pilot for integration and coordination of care team as long as the entity receiving the information and [person](#) providing the information are both authorized participants in the WPC pilot and at least one of the following conditions is met:

- The patient’s WPC participation agreement includes authorization to use and disclose mental health information.

[CA Welf. & Inst. § 14184.60(a)(6); CA Welf. & Inst. § 5328(a).]

- The coordination of care team member receiving the information and person providing the information are [qualified professional persons](#) providing services within the [treatment](#) facility.

[CA Welf. & Inst. § 5328(a).]

- The mental health information is necessary to make a claim or application for aid, insurance, or assistance on the patient’s behalf.

[CA Welf. & Inst. § 5328(c); 45 C.F.R. § 164.501; 45 C.F.R. § 164.506.]

- The coordination of care team member receiving the information and person providing the information are professionals providing medical or psychological treatment to the patient.

[CA Welf. & Inst. § 5328(a).]

- The mental health information is necessary for the coordination of care team member receiving the information to respond to a medical emergency (See [Scenario 8 - In the Event of Emergency](#)).

[CA Welf. & Inst. § 5328(a).]

If none of the above conditions is met, the mental health information can be shared between WPC participants only with a valid patient or patient representative authorization. Even if none

of the above conditions is met, a provider who is not participating in the WPC pilot may share patient information with pilot participants with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(b); 45 C.F.R. § 164.501.]

A patient's SUD information may be shared within the WPC coordination of care team if the patient's WPC participation agreement includes authorization to use and disclose SUD information. A provider not participating in the WPC pilot may share SUD patient information with pilot participants with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 14184.60(a)(6); CA Welf. & Inst. § 14184.60(c)(5); 42 C.F.R. §§ 2.31 and 2.33.]

If the patient's WPC participation agreement does not include authorization to use and disclose SUD information, the information may be shared between participants in the WPC pilot only if at least one of the following conditions is met:

- The coordination of care team member receiving the information and the provider of the information are both employed by the program (or an organization with direct administrative control of the program) to provide diagnosis, treatment or referral for treatment for the program's patients. As long as the SUD patient-identifying information is shared within the program or between the program and an organization with administrative control of the program, the sharing of information is considered internal and therefore allowed.

[42 C.F.R. § 2.12(c)(3).]

- The coordination of care team member receiving the information is employed by a [qualified service organization \(QSO\)](#) to determine patient benefit eligibility, arrange for medical assistance, or directly provide follow-up care to the program's SUD patient. The QSO must have an appropriate written agreement in effect with the program as defined in 42 C.F.R. Part 2 regulations. A QSO may not re-disclose SUD patient-identifying information without written authorization.

[42 C.F.R. §§ 2.11, 2.12(c)(4) and 2.32.]

- The SUD patient-identifying information is necessary for the person receiving the information to respond to a medical emergency (See [Scenario 8 - In the Event of Emergency](#)).

[42 C.F.R. § 2.1 § 290ee-3(b)(2)(A); CA Health & Saf. § 11845.5(c)(2).]

If none of the above conditions is met, the SUD information can be shared between WPC participants, or between a provider not participating in the WPC pilot and pilot participants, only with a valid 42 C.F.R. Part 2 patient authorization.

[42 C.F.R. §§ 2.31 and 2.33.]

Citations and Related Guidance

- 42 C.F.R. § 2.1 § 290ee-3(b)(2)(A).
- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(c)(3-4).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 2.32.
- 42 C.F.R. § 2.33.
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.506.
- CA Health & Saf. § 11845.5(c)(2).
- CA Welf. & Inst. § 5328(a-c).
- CA Welf. & Inst. § 5328.6.
- CA Welf. & Inst. § 14184.60(a)(6).
- CA Welf. & Inst. § 14184.60(c)(5).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 8 - In the Event of Emergency

Description

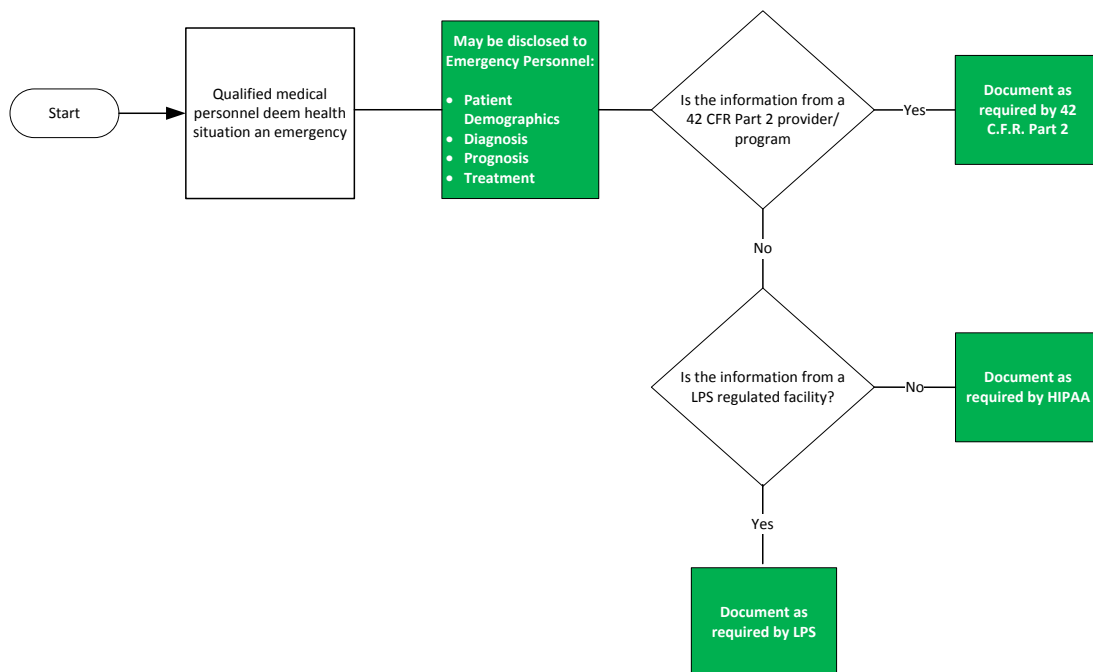
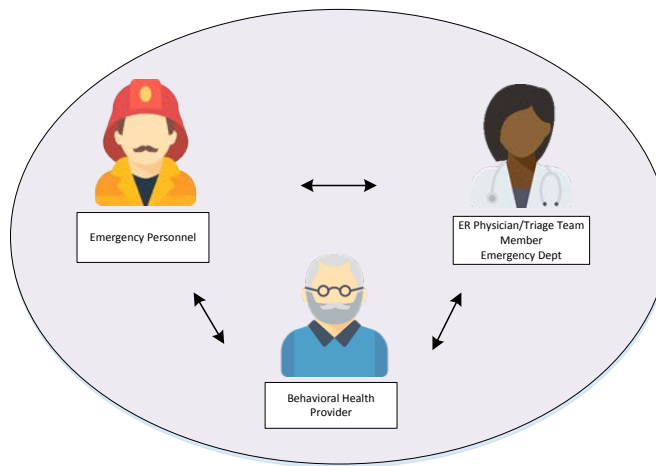
An individual with mental health or substance use disorder (SUD) issues is being treated by an Emergency Medical Services (EMS) provider, emergency room physician, hospital emergency department or a triage team member.

What patient health information can be
shared in a medical emergency?

Graphic - In the Event of Emergency

Important Scenario Guidance Assumptions:

- Must be a medical emergency as determined by **qualified healthcare professional**
- Patient is unable to provide health information to healthcare professionals
- No Patient or Patient Representative Authorization



Scenario Guidance – In Event of Emergency

Mental health providers, SUD providers (subject to 42 C.F.R. Part 2 regulations), healthcare service plans, contractors and other healthcare professionals and facilities can share the following for the purpose of diagnosis or treatment of the patient in the event of a medical emergency:

- Patient demographics
- Diagnosis
- Prognosis
- Treatment

[42 C.F.R. § 2.1 § 290ee-3 (b)(2)(A); CA Health & Saf. § 11845.5(c)(2).]

Patient health information may be communicated by radio transmissions or other means necessary between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a licensed health facility.

[45 C.F.R. § 164.506; CA Civ. Code § 56.10(c)(1); CA Welf. & Inst. § 5328(a).]

If the patient information is regulated by 42 C.F.R. Part 2, the condition being treated must pose an immediate threat to the health of the individual and require immediate medical attention. Health information protected by Lanterman-Petris-Short (LPS) may be shared when the emergency treatment personnel have medical or psychological responsibility for the patient's care

[42 C.F.R. § 2.51(a); CA Civ. Code § 56.10(c)(1); CA Welf. & Inst. § 5328(a).]

Disclosure of patient health information not protected by 42 C.F.R. Part 2 or LPS needs to be documented as required by HIPAA. Patient health information shared for treatment purposes is generally not required to be documented unless the entity making the disclosure uses electronic health records.

[42 U.S. Code § 17935(c)(1)(A); 45 C.F.R. § 164.528(a)(1)(i).]

Documentation Requirements When Provider is Regulated by 42 C.F.R. Part 2

Immediately following [disclosure](#) of [SUD patient-identifying information](#) the entity providing the information must document the following in the patient's records:

- Name and affiliation with any healthcare facility of the medical personnel to whom disclosure was made
- Name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency

[42 C.F.R. § 2.51(c).]

Documentation Requirements When Provider is Regulated by the Lanterman-Petris-Short Act

If mental health information regulated by LPS is shared for any reason, the provider making the disclosure must capture the [disclosure](#) in the patient's records and be able to document specifics of the disclosure, including the date, circumstance, names of recipient, relationship to patient, and what information was disclosed.

[CA Welf. & Inst. § 5328.6.]

Citations and Related Guidance

- 42 C.F.R. § 2.1 § 290ee-3 (b)(2)(A).
- 42 C.F.R. § 2.51(a).
- 42 C.F.R. § 2.51(c).
- 42 U.S. Code § 17935(c)(1)(A).
- 45 C.F.R § 164.506
- 45 C.F.R. § 164.528(a)(1)(i).
- CA Civ. Code § 56.10(c)(1).
- CA Health & Saf. § 11845.5(c)(2).
- CA Welf. & Inst. § 5328(a).
- CA Welf. & Inst. § 5328.6.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Payment and Determination of Benefits

When allowed by law, [protected health information \(PHI\)](#) can be shared for purposes of applying for or making a claim for assistance or benefits on behalf of a patient. Benefits or assistance may include [payment](#) of claims, medical assistance, aid, insurance and government benefits. PHI includes patient-specific information about mental health, substance use disorder (SUD) and general healthcare. Within their respective centers, programs, or care facilities/networks, behavioral healthcare providers may share patient health information without patient [authorization](#) for purposes of applying for or making a claim for assistance or benefits on behalf of a patient.

The ability to share PHI for the above purposes outside a provider's center, program, or care facility/network varies depends on whether the patient information is regulated by 42 C.F.R. Part 2. For SUD, 42 C.F.R. Part 2 establishes stringent standards for use and [disclosure](#) of patient-identifying information. Patient authorization is required when SUD patient-identifying information is disclosed for purposes of applying for or making a claim for benefits or assistance unless specific criteria (explained in more detail below) is met.

Scenario 9 - Behavioral Health to Social Services for Payment and Determination of Benefits

Description

A behavioral healthcare provider wants to share a patient's behavioral health information with a social services case manager (SSCM) to apply for or arrange social services benefits on behalf of the patient. Such information might include [substance use disorder \(SUD\) patient-identifying information](#) or Lanterman-Petris-Short (LPS) regulated [mental health information](#).

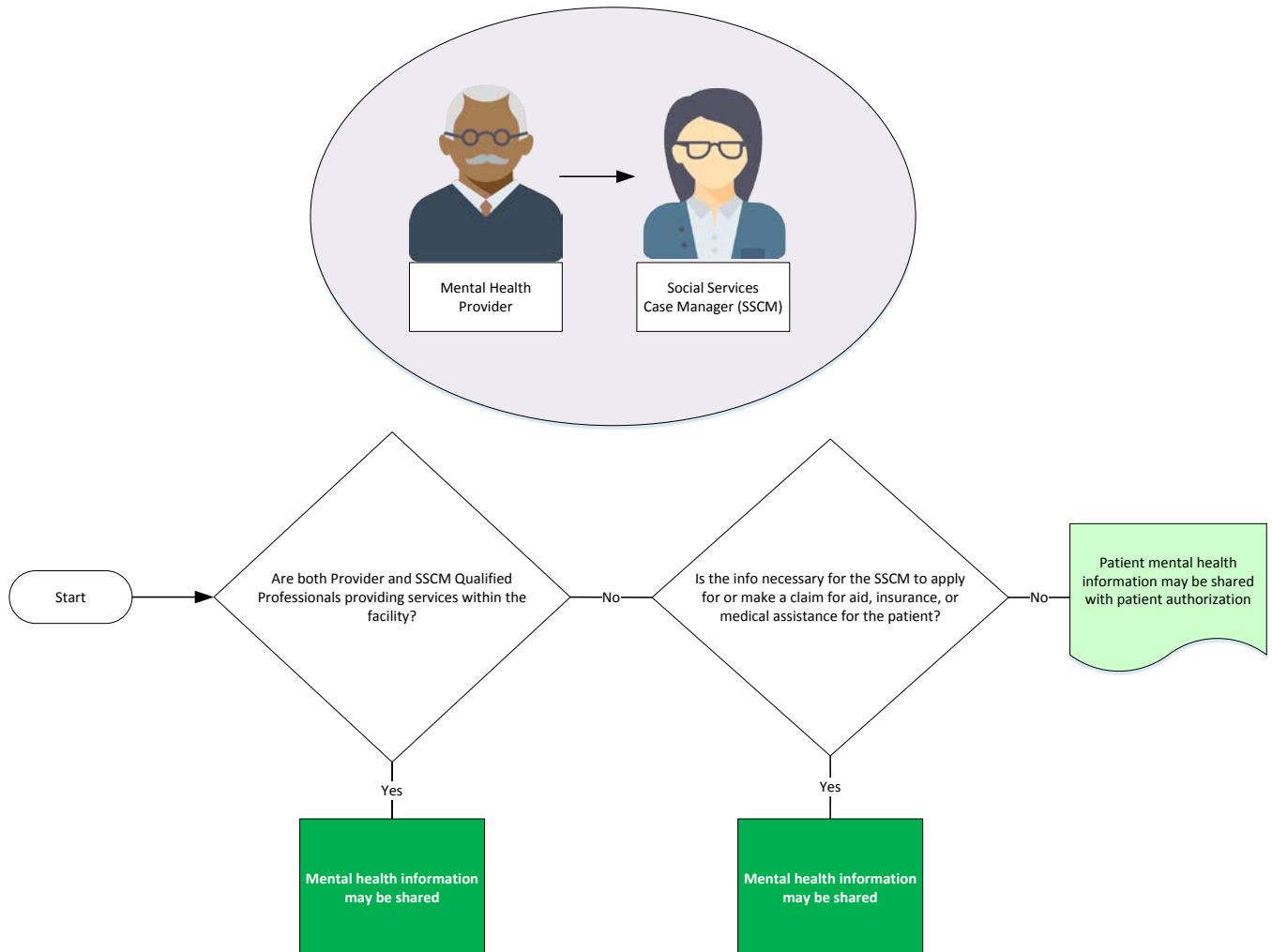
What patient health information can a behavioral health provider share with the social services case manager?

Graphic - Behavioral Health to Social Services for Payment and Determination of Benefits

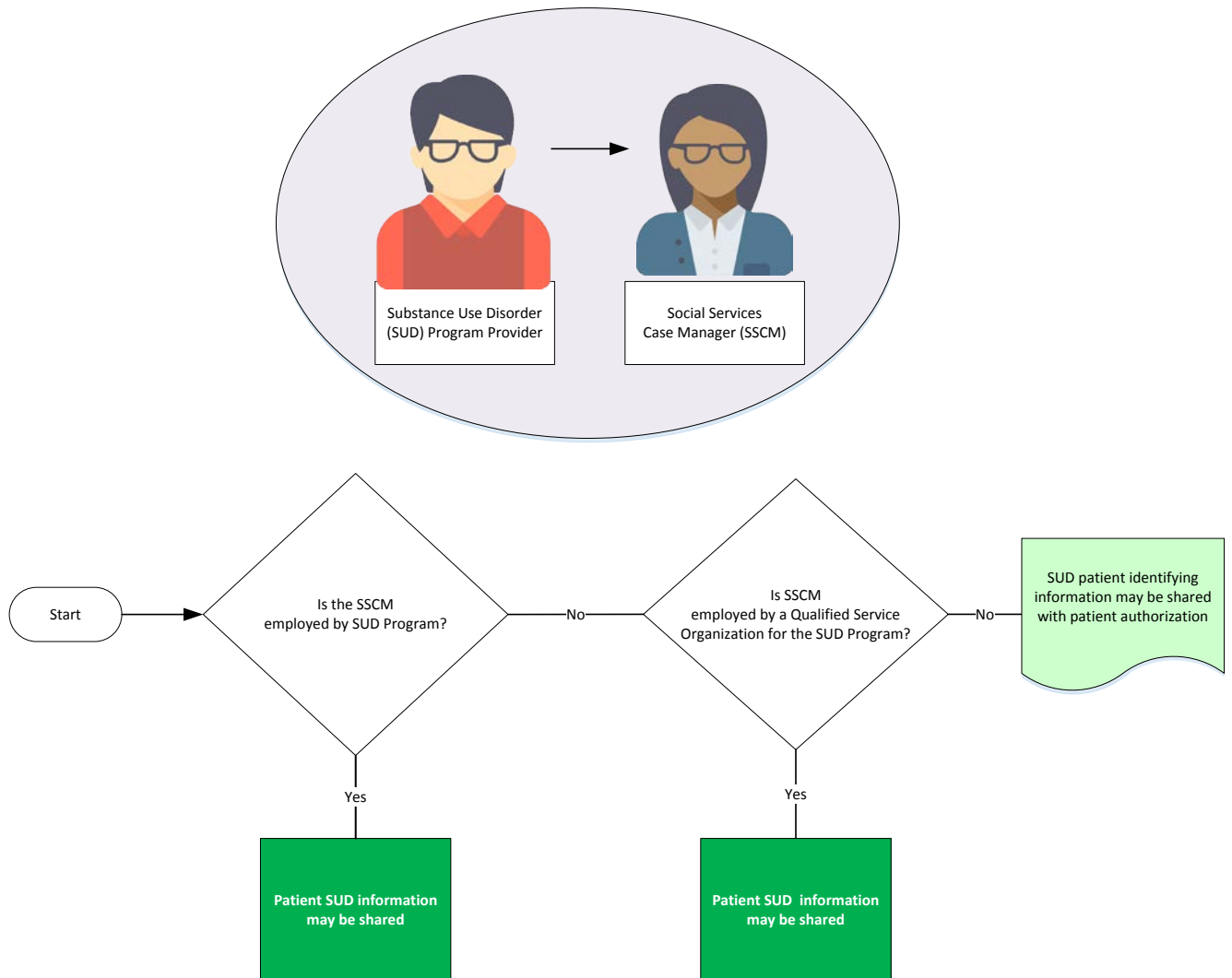
Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order
- There is no medical emergency
- [Mental health information](#) for this scenario is regulated by the Lanterman-Petris-Short Act (LPS)
- [SUD patient identifying information](#) for this scenario is regulated by 42 C.F.R. Part 2

Mental Health



Substance Use Disorder



Scenario Guidance – Behavioral Health to Social Services for Payment and Determination of Benefits

For purposes of applying for or making a claim for assistance or benefits (including social services assistance or benefits) on behalf of a patient, current regulations vary depending on whether the behavioral health information is regulated by LPS (mental health) or 42 C.F.R. Part 2 regulations (SUD). If the purpose of sharing behavioral health information with a SSCM is specifically to make a claim for assistance or benefits on behalf of the patient, the PHI may be shared without a patient authorization under the conditions described in the following paragraphs.

A mental health provider may [disclose](#) PHI to a SSCM if either of the following criteria is met:

- The SSCM receiving the information and [person](#) providing the information are [qualified professional persons](#) providing services within the treatment facility.
[CA Welf. & Inst. § 5328(a).]
- The mental health information is necessary to make a claim or application for aid, insurance, or medical assistance on the patient's behalf.
[CA Welf. & Inst. § 5328(c).]

If neither of the above conditions is met, the mental health information can be shared with a SSCM only with a valid patient or patient representative authorization.

[CA Civ. Code § 56.10(a); CA Welf. & Inst. § 5328 (b); 45 C.F.R. § 164.501.]

If mental health information is shared for any reason outside of the treatment facility or program, the disclosure must be documented in the patient's medical records and include the date, circumstance, names of recipient, relationship to patient, and what information was disclosed.

[CA Welf. & Inst. § 5328.6.]

SUD patient-identifying information is highly sensitive and specially protected under federal law. Without patient authorization, disclosure is strictly regulated for any patient information that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a [SUD treatment program](#) that receives federal assistance. Since federal assistance is broadly defined in regulations and includes Medicare and Medicaid [payments](#), a significant percentage of SUD patient-identifying information falls under the strict federal regulations, often referred to as "Part 2" regulations.

Despite the restrictions, a SUD provider may disclose PHI to a SSCM without a patient authorization if either of the following criteria is met:

- The SSCM is employed by the program (or an organization with direct administrative control of the program) to provide diagnosis, treatment or referral for treatment for the program's patients. Treatment means the management and care of a SUD patient in order to reduce or eliminate the adverse effects of SUD on the patient, which may include care coordination after inpatient services. As long as the SUD patient-identifying information is shared within the program or between the program and an organization with administrative control of the program, the sharing of information is internal and therefore allowed.

42 C.F.R. § 2.12(c)(3); CA Health & Saf. § 11845.5(c)(1).]

- The SSCM is employed by a [qualified service organization \(QSO\)](#) to determine patient benefit eligibility, arrange for medical assistance, or directly provide follow-up care to the program's SUD patient. The QSO must have an appropriate written agreement in effect with the program as defined in the 42 C.F.R. Part 2 regulations.

[42 C.F.R. §§ 2.11 and 2.12(c)(4).]

If neither of the above conditions is met, the SUD patient-identifying information can be shared with a SSCM only with a valid SUD patient authorization. In the case of a SSCM, the written authorization for a disclosure of SUD patient-identifying information must specify the name of the individual to which disclosure will be made.

[42 C.F.R. § 2.31.]

Citations and Related Guidance

- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(c)(3-4).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 164.501.
- CA Health & Saf. § 11845.5(c)(1).
- CA Welf. & Inst. § 5328(a-c).
- CA Welf. & Inst. § 5328.6.
- CA Civ. Code § 56.10(a).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Healthcare Business Operations

Healthcare business operations are certain administrative, financial, legal, and quality improvement activities that are necessary for a Health Insurance Portability and Accountability Act (HIPAA) covered entity to run its business. Even within the context of these activities, entities are required to ensure sensitive patient mental health information and substance use disorder (SUD) patient-identifying information is protected in accordance with HIPAA, California Medical Information Act (CMIA), Lanterman-Petris-Short (LPS) Act, and 42 C.F.R. Part 2 – Confidentiality of Substance Use Disorder Patient Records.

Scenario 10 - Quality Improvement

Description

The disclosure and use of [protected health information \(PHI\)](#) is a key requirement to support quality improvement activities, which are in turn essential to the Triple Aim¹⁰ of improving the patient experience of care, improving the health of populations, and reducing per capita costs of healthcare.

Healthcare business operations activities, which include quality improvement activities, may require the exchange of [behavioral health information](#) between [healthcare providers](#), [health plans](#), [business associates](#), [quality service organizations \(QSO\)](#), and accountable care organization (ACO) participants. The extent that behavioral health information can be shared for the above-mentioned purpose depends on the State or federal law by which the patient information is regulated.

Under what circumstances can behavioral health information be shared for quality assessment and improvement activities?

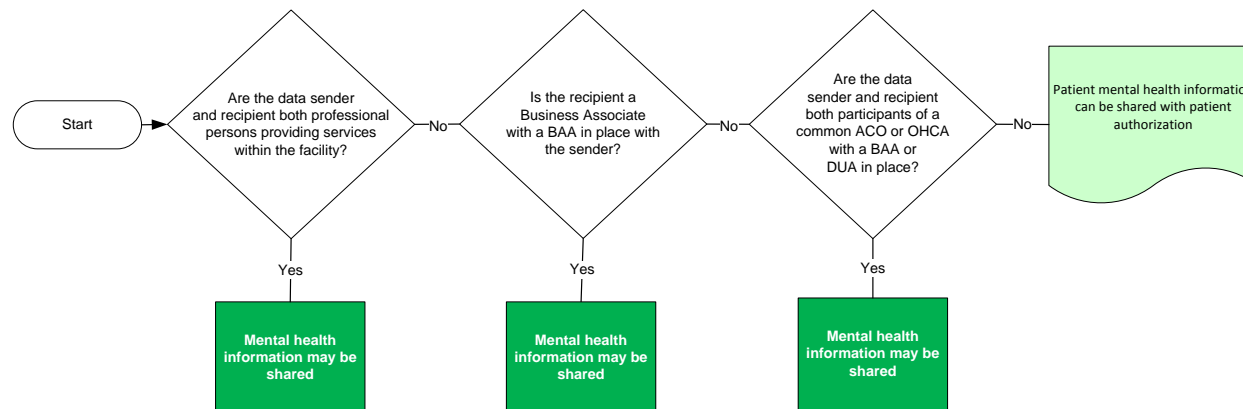
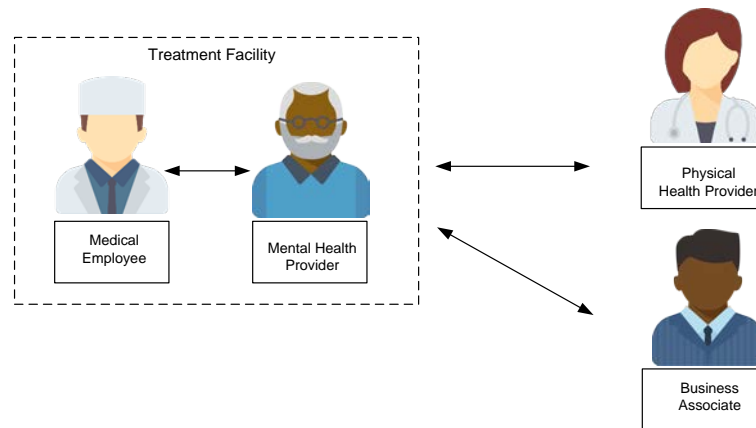
¹⁰ Institute for Healthcare Improvement, “Triple Aim Initiative,” 2017, <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

Graphic - Quality Improvement

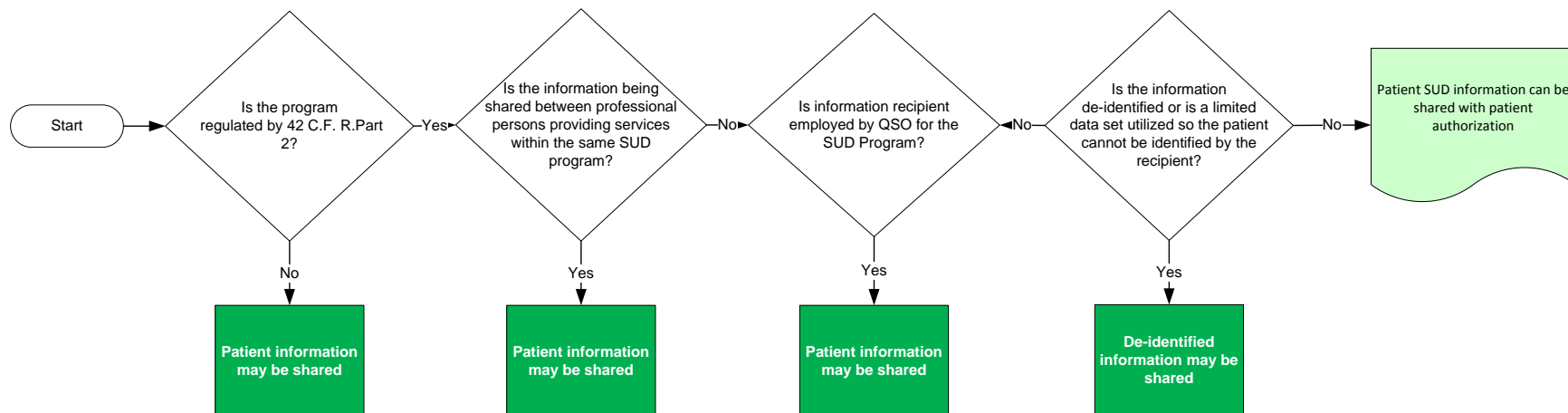
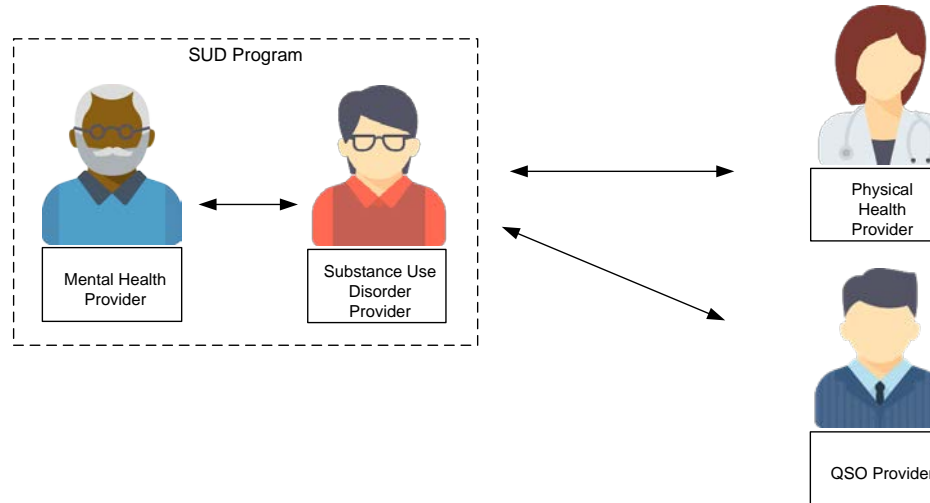
Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order

Mental Health



Substance Use Disorder



Scenario Guidance – Quality Improvement

Mental Health Information

Lanterman-Petris-Short (LPS) regulated mental health information may be [disclosed](#) without patient authorization only by a professional employed by the treatment facility to a professional person who has medical or psychological responsibility for the patient. If this condition is not met, the mental health information can be shared only with a valid patient or patient representative authorization. If LPS-regulated mental health information is shared for any reason, the disclosure must be documented in the patient’s medical records and include the date, circumstance, names of recipient, relationship to patient, persons and agencies to whom such disclosure was made, and what specific information was disclosed. Mental health information shared between [qualified professional persons](#) employed by the same facility or program and have medical or psychological responsibility for the patient’s care need not be documented in the patient’s medical records.

[CA Welf. & Inst. § 5328(a) and (b); § 5328.6.]

Regulations governing the disclosure of mental health information for quality improvement purposes are covered under HIPAA uses and disclosures to carry out [treatment](#), [payment](#), or [healthcare operations](#).

[45 C.F.R. § 164.506.]

PHI may be shared with business associates in order to carry out, assist with the performance of, or perform a function or activity on behalf of a [covered entity](#). A business associate is permitted to use or disclose health information only in the manner specified in an executed legal agreement between the covered entity and their organization to protect health information in accordance with HIPAA guidelines. Examples of legal agreements include a [business associate agreement \(BAA\)](#) and a [data use agreement \(DUA\)](#). When sharing protected health information or when requesting PHI from another covered entity or business associate, a covered entity or business associate must make reasonable efforts to limit protected health information to the [minimum necessary](#) to accomplish the intended purpose of the use, disclosure, or request.

[45 C.F.R. § 160.103; 45 C.F.R. §§ 164.308(b)(1-3) and 164.504.]

A covered entity (e.g. health plan or healthcare provider) that participates in an [organized health care arrangement \(OHCA\)](#) such as an ACO, may disclose PHI to other OHCA participants or business associate of an OHCA participant for any healthcare operations activities of the OHCA including quality assessment and improvement activities.

[45 C.F.R. §§ 164.502(a)(5) and 164.506.]

Substance Use Disorder Health Information

[Substance use disorder \(SUD\) patient-identifying information](#) regulated by 42 C.F.R Part 2 is highly sensitive and specially protected under federal law. Without patient authorization, disclosure is strictly regulated for any patient information that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a [SUD treatment program](#) (as defined by 42 C.F.R. Part 2) that receives federal assistance. Since federal assistance is broadly defined in regulations and includes Medicare and Medicaid payments, a significant percentage of SUD patient-identifying information falls under 42 C.F.R. Part 2 regulations.

[42 C.F.R. § 2.12(c)(3).]

Despite the restrictions, a SUD provider may disclose information without a patient authorization if any of the following conditions are met:

- The SUD patient-identifying information is shared within the SUD provider's facility or between the program and an organization with administrative control of the program.
[42 C.F.R. § 2.12(c)(3).]
- The recipient is employed by a QSO and the information is needed to provide support services to the program. The QSO must have an appropriate written agreement in effect with the program as defined in the 42 C.F.R. Part 2 regulations.
[42 C.F.R. § 2.12(c)(4).]
- The program provider can share patient information in such a way that the patient cannot be identified as a SUD patient directly, by reference to other publicly available information, or by verification as an SUD patient by another person.

[42 C.F.R. § 2.12(a)(1); CA Civ. Code § 56.10(c).]

If none of these conditions are met, the SUD patient-identifying information can be shared only with a valid SUD patient authorization.

[42 C.F.R. § 2.31.]

Citations and Related Guidance

- 42 C.F.R. § 2.12(a)(1)
- 42 C.F.R. § 2.12(c)(3-4).
- 42 C.F.R. § 2.31.
- 45 C.F.R. § 160.103.
- 45 C.F.R. § 164.308(b)(1-3).
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.502(a)(5).
- 45 C.F.R. § 164.504.
- 45 C.F.R. § 164.506.
- CA Civ. Code § 56.10(c).
- CA Welf. & Inst. § 5328(a-c)
- CA Welf. & Inst. § 5328.6.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 11 - Audits

Description

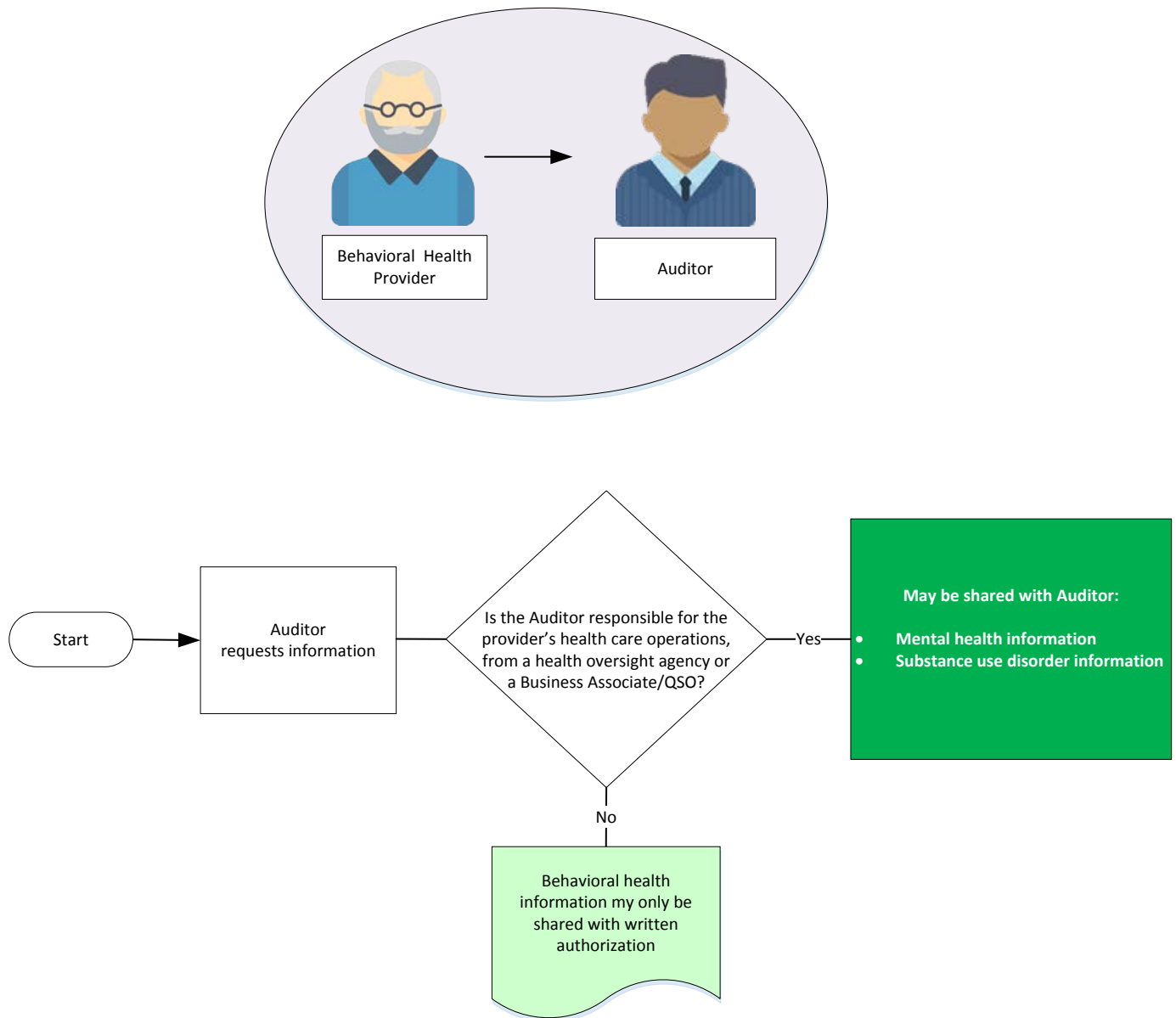
Auditors in the performance of their duties may ask for health information that includes patient [mental health information](#) or [substance use disorder \(SUD\) patient-identifying information](#) that is protected by 42 C.F.R. Part 2, Lanterman-Petris-Short (LPS) Act, Confidentiality of Medical Information Act (CMIA), or Health Insurance Portability and Accountability Act (HIPAA).

What patient health information can a provider share with an auditor during an audit?

Graphic - Audits

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order



Scenario Guidance – Audits

Auditing is an important part of an entity's quality management system to ensure compliance for requirements for the management of quality standards and practices. [Protected health information \(PHI\)](#), including mental health and SUD, can be shared for [healthcare operations](#) and [health oversight activities](#). Conducting or arranging for medical review, legal services, and auditing functions, including financial audits, fraud and abuse detection and compliance programs is considered healthcare operations and patient authorization is not required. Health information may be [disclosed](#) to a [health oversight agency](#), without an authorization, for authorized oversight activities (examples include, but are not limited to, audits, licensure or disciplinary actions).

[45 C.F.R. § 164.501; 45 C.F.R. § 164.512(d); CA Civ. Code § 56.10(c)(3); CA Health & Saf. § 11845.5(c)(3).]

Regulations governing the disclosure of mental health information during an audit are covered under HIPAA Privacy Disclosures for Public Health Activities. The rule permits covered entities to use or disclose without authorization protected health information to a health oversight agency for oversight activities authorized by law (e.g., management or financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals).

[45 C.F.R. § 164.512(d); CA Civ. Code § 56.10(c)(3); CA Welf. & Inst. § 5328.]

When conducting [research](#), management or financial audits, or program evaluation for [SUD treatment programs](#), health information can be disclosed to qualified professional persons, as long as any report on such activities does not identify patients in any way. A researcher must provide documentation they meet all the requirements related to protections for human research. *Qualified professional persons* are individuals whose training and experience are appropriate to the nature and level of work they are doing, as long as they are working as part of an organization with adequate [administrative safeguards](#) against unauthorized disclosures for the work being performed.

[42 C.F.R. §§ 2.12(c)(3), 2.2(b)(2), and 2.53; 42 U.S.C. § 290ee-3(b)(2)(B); CA Health & Saf. § 11845.5(c)(3).]

[Qualified service organizations \(QSO\)](#) provide services to a program and are granted [access](#) to SUD patient-identifying information in the performance of their responsibilities without a patient authorization. A QSO must have a written agreement with the program that acknowledges being fully bound by these regulations and provides services to the program (e.g.; data processing; bill collecting; laboratory analyses; legal, medical, accounting, or other professional services; services to prevent or treat child abuse or neglect).

[42 C.F.R. §§ 2.11, 2.12(c)(4), and 2.12(d)(2); CA Health & Saf. § 11845.5(c)(3).]

Citations and Related Guidance

- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(c)(3).
- 42 C.F.R. § 2.12(c)(4).
- 42 C.F.R. § 2.12(d)(2).
- 42 C.F.R. § 2.2(b)(2).
- 42 C.F.R. § 2.53.
- 42 U.S.C. § 290ee-3(b)(2)(B).
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.502(b)(2)(iii).
- 45 C.F.R. § 164.512(d).
- CA Civ. Code § 56.10(c)(3).
- CA Health & Saf. § 11845.5(c)(3).
- CA Civ. § 5328.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 12 - Business Associates

Description

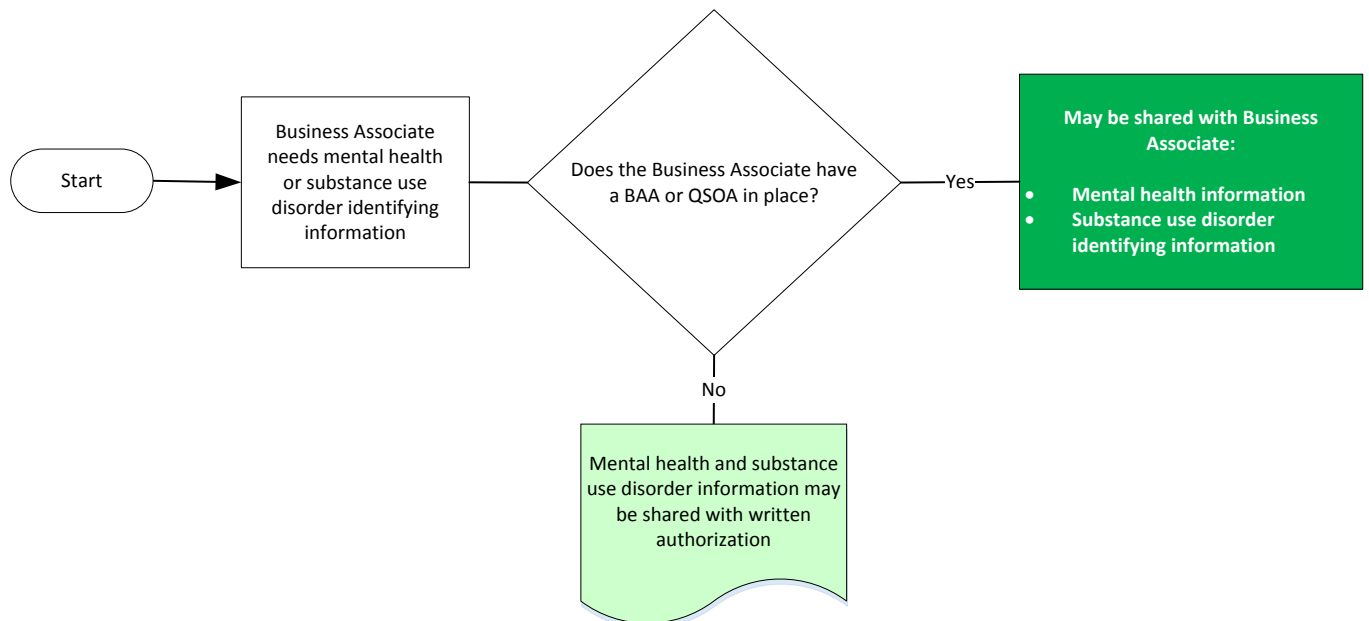
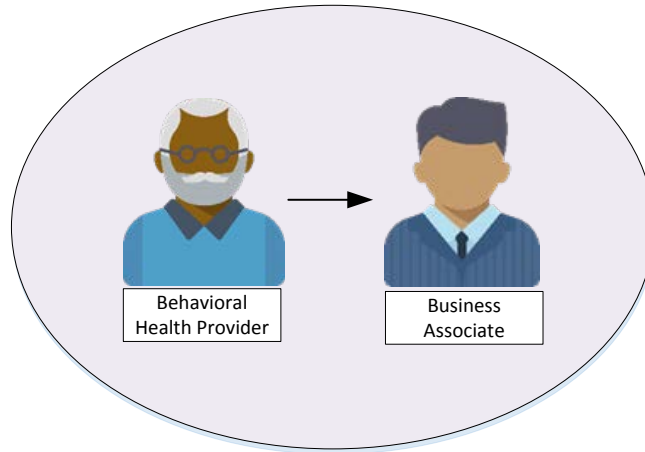
A [business associate](#) in the performance of their duties needs [access](#) to health information including patient [mental health information](#) or [substance use disorder \(SUD\) patient-identifying information](#) protected by 42 C.F.R. Part 2, Lanterman-Petris-Short (LPS) Act, Confidentiality of Medical Information Act (CMIA), or Health Insurance Portability and Accountability Act (HIPAA).

What patient health information can a behavioral health provider share with their business associates?

Graphic - Business Associates

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order



Scenario Guidance – Business Associates

PHI may be shared with business associates in order to carry out, assist with the performance of, or perform a function or activity on behalf of a [covered entity](#). A [business associate agreement \(BAA\)](#) is executed to protect health information in accordance with HIPAA guidelines. A business associate is permitted to use or [disclose](#) health information only in the manner specified in an executed legal agreement between the covered entity and their organization. [SUD treatment programs](#) regulated by 42 C.F.R. Part 2 have similar latitude with a [qualified service organizations \(QSO\)](#). Even with a BAA or a [qualified service organization agreement \(QSOA\)](#), disclosure or sharing of mental health information and SUD patient-identifying information is subject to the specific restrictions of federal and State [privacy](#) law.

[45 C.F.R. § 164.308(b), § 164.314(a)(1-2), § 164.502, § 164.504(e)(1-2), and § 164.504(e)(3)(i); CA Civ. Code § 56.10; CA Health & Saf. § 11845.5(c)(3); 42 C.F.R. § 2.1; 42 U.S.C. § 290ee-3(b)(2)(B).]

Business associates may include:

- Organizations that provide services (e.g., claims processing, clearing houses, data analysis, utilization review, quality assurance, billing, legal) on behalf of a covered entity where access to [protected health information](#) is required
- A [person](#) that offers a personal health record to one or more individuals on behalf of a covered entity
- A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate

[45 C.F.R. § 160.103.]

A business associate is permitted to use or disclose health information only in the manner specified in an executed legal agreement between their organization and the covered entity. This includes information about any restrictions for the use or disclosure of information as requested by the patient as well as any requests by the patient regarding confidential communications.

Each entity may have specific program requirements that may need to be incorporated into the BAA. The BAA must provide that the business associate will comply with all applicable requirements.

[45 C.F.R. § 164.314.]

Mental Health Information

Mental health information may be shared with business associates provided a current signed BAA is in place. When sharing protected health information or when requesting protected health information from another covered entity or business associate, a covered entity or

business associate must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

[45 C.F.R. § 160.103; 45 C.F.R. § 164.502(b)(2)(iii); 45 C.F.R. § 164.504.]

Substance Use Disorder Health Information

Substance use disorder (SUD) patient-identifying information may be shared with a QSO to provide services to the program. A QSO is one that has entered into a written agreement with the program that acknowledges being fully bound by these regulations and provides services to the program (e.g.; data processing; bill collecting; dosage preparation; laboratory analyses; legal, accounting, population health management, medical staffing or other professional services; services to prevent or treat child abuse or neglect including training on nutrition and child care and individual and group therapy). Any information identifying a patient as being or having been diagnosed with or treated for a SUD either directly or indirectly should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. A QSO may re-disclose SUD patient-identifying information only with written authorization.

[42 C.F.R. §§ 2.11, 2.12(c)(4), 2.12(d)(2) and 42 C.F.R. § 2.32; 45 C.F.R. §164.502(b)(2)(iii); CA Health & Saf. § 11845.5(c)(1).]

Citations and Related Guidance

- 42 C.F.R. § 2.1.
- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(c)(4).
- 42 C.F.R. § 2.12(d)(2).
- 42 C.F.R. § 2.32.
- 42 U.S.C. 290ee-3(b)(2)(B)
- 45 C.F.R. § 160.103.
- 45 C.F.R. § 164.308(b).
- 45 C.F.R. § 164.314(a)(1-2).
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.502(b)(2)(iii).
- 45 C.F.R. § 164.504.
- CA Civ. Code § 56.10.
- CA Health & Saf. § 11845.5(c)(1) and (c)(3).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 13 - Behavioral Health Organization Policy and Strategy Development

Description

Like all organizations, a healthcare entity needs to develop strategies and policies to improve the effectiveness of the organization. In most cases strategic planning is performed by leadership and consulting teams, often using data that includes summarized patient information, public health and industry trends, and changing regulations. When summarized patient information is used to inform development of organizational strategy and policy, it can provide distinct insights into opportunities and risks.

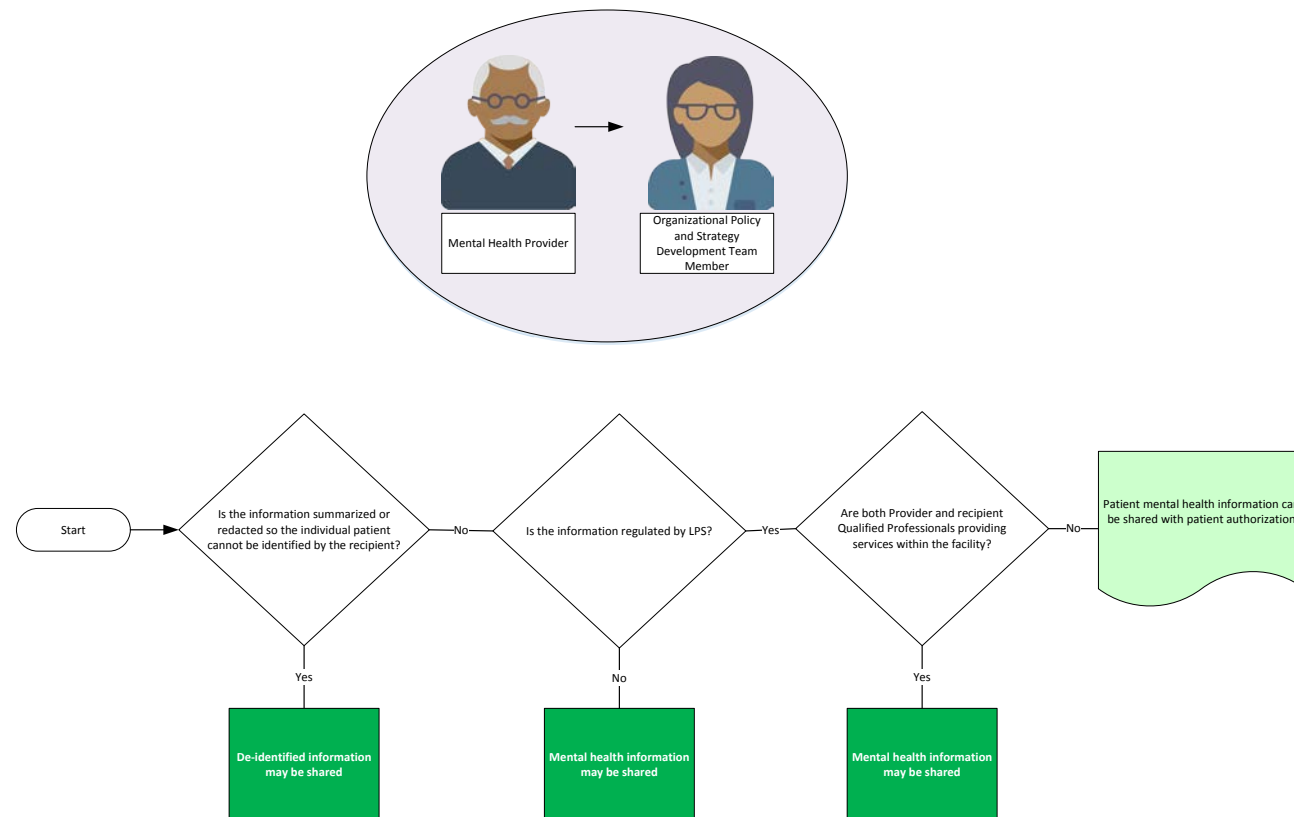
What patient health information can a behavioral health provider share with a team developing strategy and policy for an organization?

Graphic - Behavioral Health Organization Policy and Strategy Development

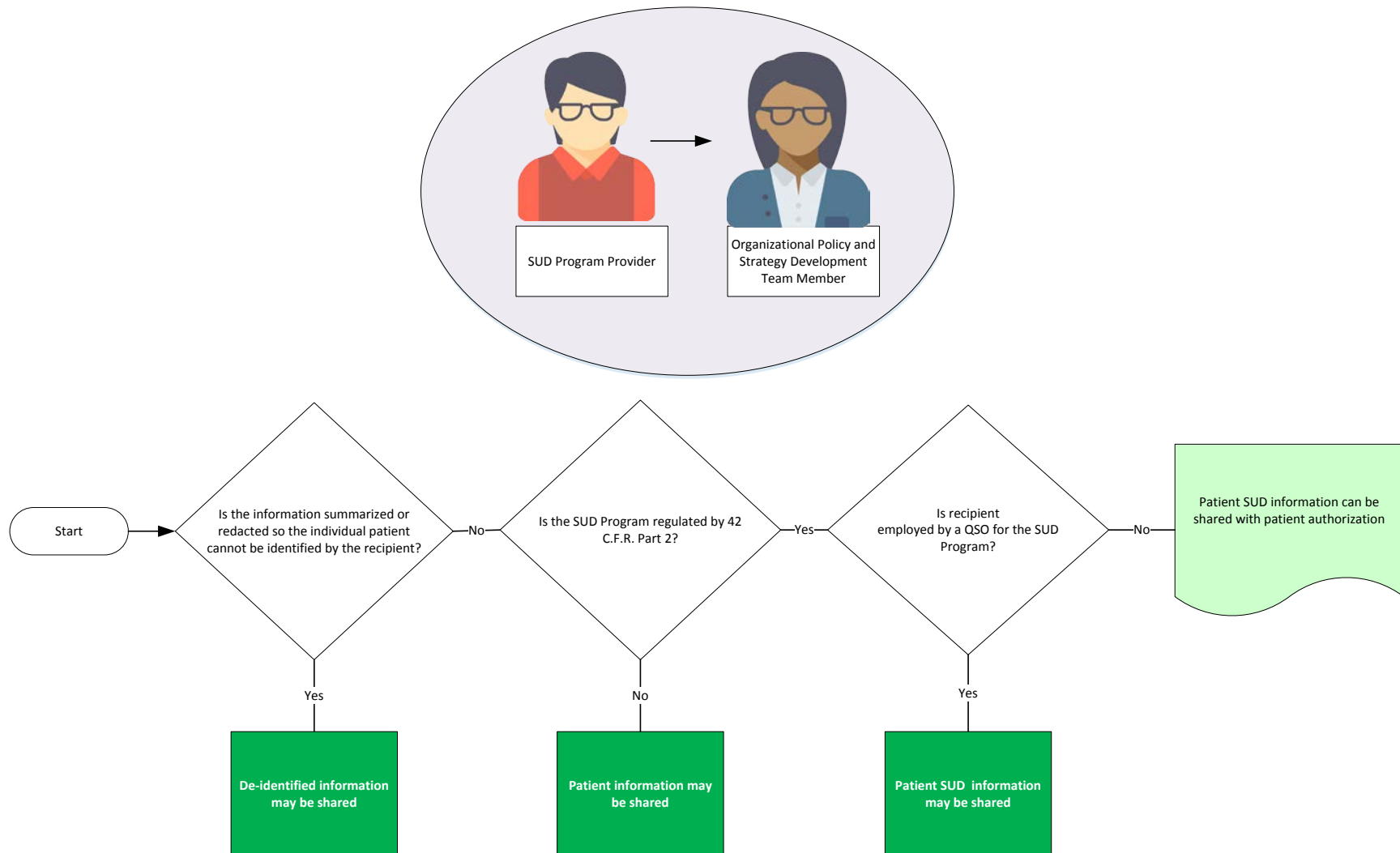
Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order

Mental Health



Substance Use Disorder



Scenario Guidance – Behavioral Health Organization Policy and Strategy Development

For purposes of developing organizational strategy and policy, compiled or summarized [mental health information](#) and [substance use disorder \(SUD\) patient-identifying information](#) can be shared with strategic planning teams if patient identities cannot be determined from the data [disclosed](#). Patient [behavioral health information](#), however, is [specially protected health information](#) and may only be shared under the conditions described in the following paragraphs.

In general, if the information does not expose a patient's identity, it may be used by the team for organizational planning purposes without patient authorization. If the information used for such organizational purposes does identify individual patients, the patient information is protected by State and federal regulations and can be shared without an authorization only under certain conditions.

A mental health provider may disclose LPS-regulated PHI to a team developing organizational strategy and policy only if the [person](#) providing the information and the person(s) receiving the information are [qualified professional persons](#) providing services within the [treatment](#) facility. If this condition is not met, the mental health information can be shared with the team only with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(a-b).]

A mental health provider not regulated by LPS may disclose PHI to a team developing organizational strategy and policy as permitted by the Health Insurance Portability and Accountability Act (HIPAA) and California Medical Information Act (CMIA) for business planning and development related to managing and operating the entity.

[45 C.F.R. §§ 164.501 and 164.506.]

SUD patient-identifying information is highly sensitive and specially protected under federal law. Without patient authorization, disclosure is strictly regulated for any patient information that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a [SUD treatment program](#) that receives federal assistance. Since federal assistance is broadly defined in regulations and includes Medicare and Medicaid [payments](#), a significant percentage of SUD patient-identifying information falls under the strict federal regulations, often referred to as "Part 2" regulations.

Despite the restrictions, a SUD provider may disclose information without a patient authorization to a team developing organizational strategy or policy if the information shared does not identify the individual as a past or present SUD patient. In addition, a SUD provider may disclose patient-identifying information to a team developing organizational strategy or policy without a patient authorization if the team developing the organizational policy and strategy is part of a [qualified service organization \(QSO\)](#). The QSO must have an appropriate

written agreement in effect with the program as defined in the 42 C.F.R. Part 2 regulations. A QSO may not re-disclose SUD patient-identifying information without written authorization.

[42 C.F.R. §§ 2.11, 2.12(c)(4), and 2.32.]

If this condition is not met, the SUD patient-identifying information can be shared with a planning team only with a valid SUD patient authorization. The required elements of a written authorization for the use and disclosure of SUD treatment records may be found in [Appendix 2 - Patient Authorization for Use or Disclosure](#).

[42 C.F.R. §§ 2.31 and 2.33.]

Citations and Related Guidance

- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(c)(4).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 2.32.
- 42 C.F.R. § 2.33.
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.506.
- CA Welf. & Inst. § 5328(a-b).
- CA Welf. & Inst. § 5328.6.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Law Enforcement

The extent of patient health information a behavioral health facility can share when requested by a [law enforcement official](#) is limited. The specific information that can be shared depends on whether the facility is a substance use disorder (SUD) provider or facility (regulated by 42 C.F.R. Part 2).

Scenario 14 - Law Enforcement Official Requesting Information from a Substance Use Disorder Treatment Facility

Description

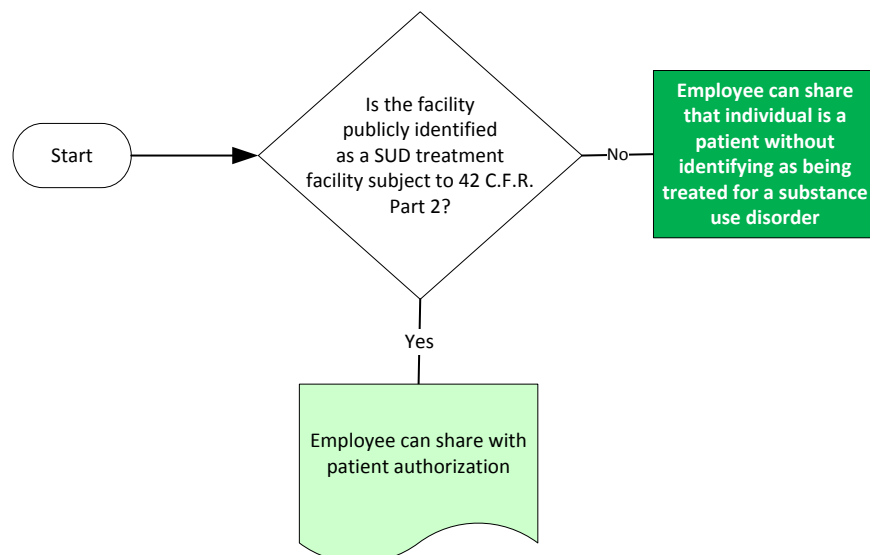
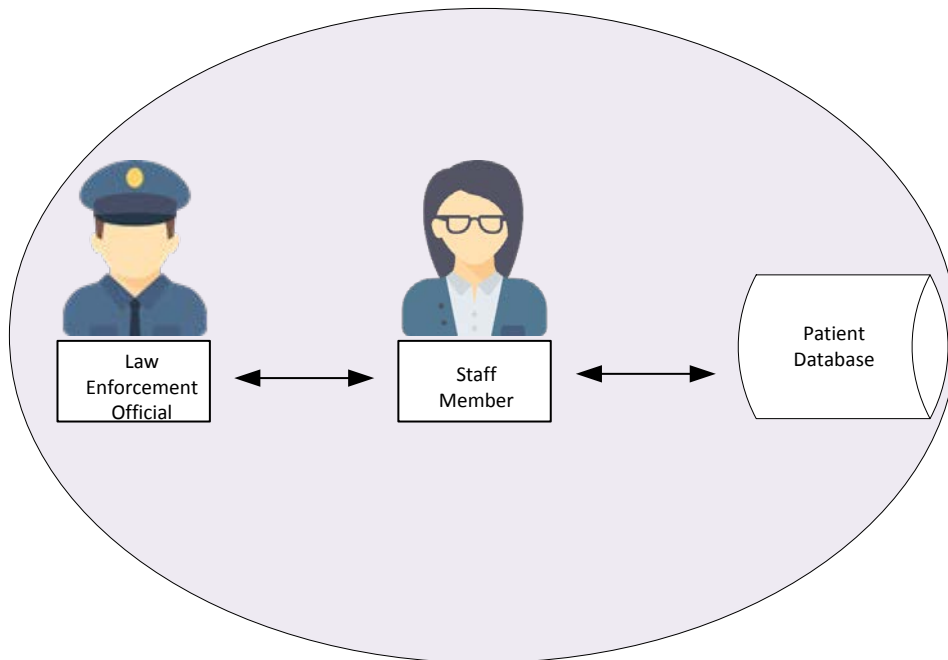
A law enforcement official investigating a crime asks for information from an employee in the reception area of a SUD treatment facility (regulated by 42 C.F.R. Part 2) about a person who is reportedly a patient.

What patient information can be shared with the law enforcement official?

Graphic - Law Enforcement Official Requesting Information from a Substance Use Disorder Treatment Facility

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- The officer has no court order



Scenario Guidance – Law Enforcement Official Requesting Information from a Substance Use Disorder Treatment Facility

Employees of a publicly-identified SUD treatment facility regulated by 42 C.F.R. Part 2 are limited by law in the patient-identifying SUD information they can provide to a law enforcement official, such as police officer, sheriff's deputy or detective. Without an appropriate authorization or a sufficient court order to release SUD patient information, limited information may be released. While it is legal to acknowledge the identity of a patient who is not and has never been a patient in a 42 C.F.R. Part 2 regulated facility, it is recommended that no information be provided for past or current patients or individuals who have never been a patient. Remaining silent on the identity of a current or past patient while providing information on a patient who is not or has never been a patient can inadvertently compromise patient [privacy](#). 42 C.F.R. Part 2 regulations do not prohibit entities from refusing to disclose whether the individual is not and never has been a patient.

[42 C.F.R. § 2.13(c)(1-2); CA Health & Saf. §§ 11845.5(a-b), 11845.5(c)(4), and 11845.5(e).]

If the facility is not subject to 42 C.F.R. Part 2, regulations permit acknowledging the presence of an identified patient in a health care facility. The acknowledgement must not reveal that the patient has a substance use disorder.

[42 C.F.R. § 2.13(c)(1).]

Citations and Related Guidance

- 42 C.F.R. §§ 2.13(c)(1-2).
- 42 U.S.C. § 290dd-2.
- CA Health & Saf. § 11845.5(a-c).
- CA Health & Saf. § 11845.5(e).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 15 - Law Enforcement Official Requesting Information from Mental Health Facility

Description

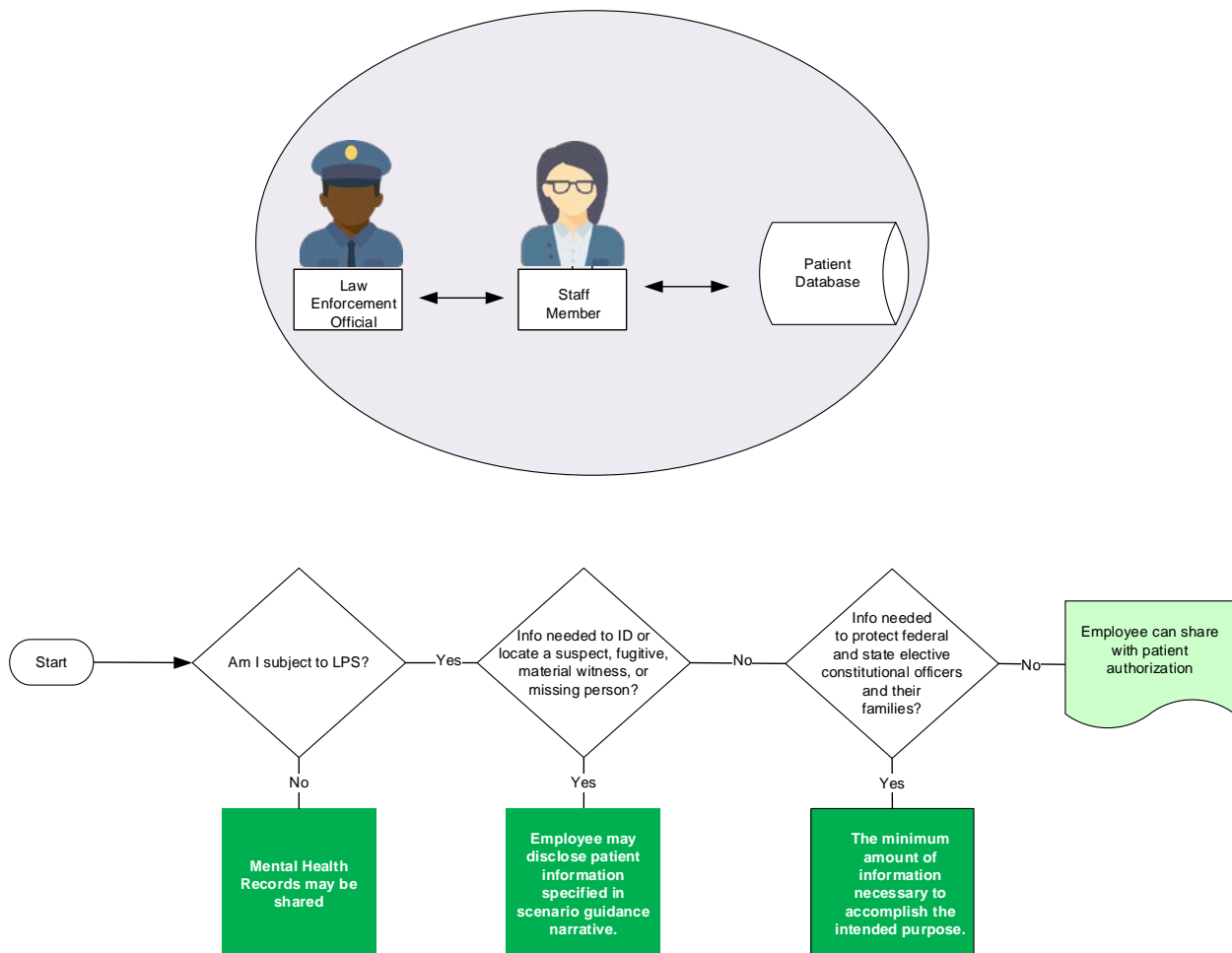
A [law enforcement official](#) investigating a crime asks for patient information from an employee in the reception area of a mental health facility regulated by Lanterman-Petris-Short (LPS) Act.

What patient information can be shared with the law enforcement official?

Graphic - Law Enforcement Official Requesting Information from Mental Health Facility

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- The officer has no court order
- Employee is authorized by the facility to [access](#) patient information



Scenario Guidance – Law Enforcement Official Requesting Information from Mental Health Facility

Employees of a mental health facility are limited by law in the information they can provide to a law enforcement official, such as police officer, sheriff's deputy or detective. Without an appropriate authorization or a sufficient court order to release information, an employee is allowed to [disclose](#) only the following information about a specific individual:

For the Protection of Elective Constitutional Officers

Disclosure of patient information must be released, as needed, to law enforcement officials to protect federal and State elective constitutional officers and their families.

[CA Welf. & Inst. § 5328(g).]

For Identification and Location Purposes

A mental health facility may disclose [protected health information \(PHI\)](#) in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.

[45 C.F.R. § 164.512(f)(1)(i).]

Only the following information may be disclosed:

- Name
- Address
- Date of birth
- Place of birth
- Social Security Number
- ABO blood type and Rh factor
- Type of injury
- Date and time of treatment
- Date and time of death, if applicable
- A description of distinguishing physical traits, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

[45 C.F.R. § 164.512(f)(2)(i).]

Citations and Related Guidance

- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.512(f)(1)(i).
- 45 C.F.R. § 164.512(f)(2)(i).
- CA Welf. & Inst. § 5328(g).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 16 - Patient Being Released from Involuntary Hospitalization

Description

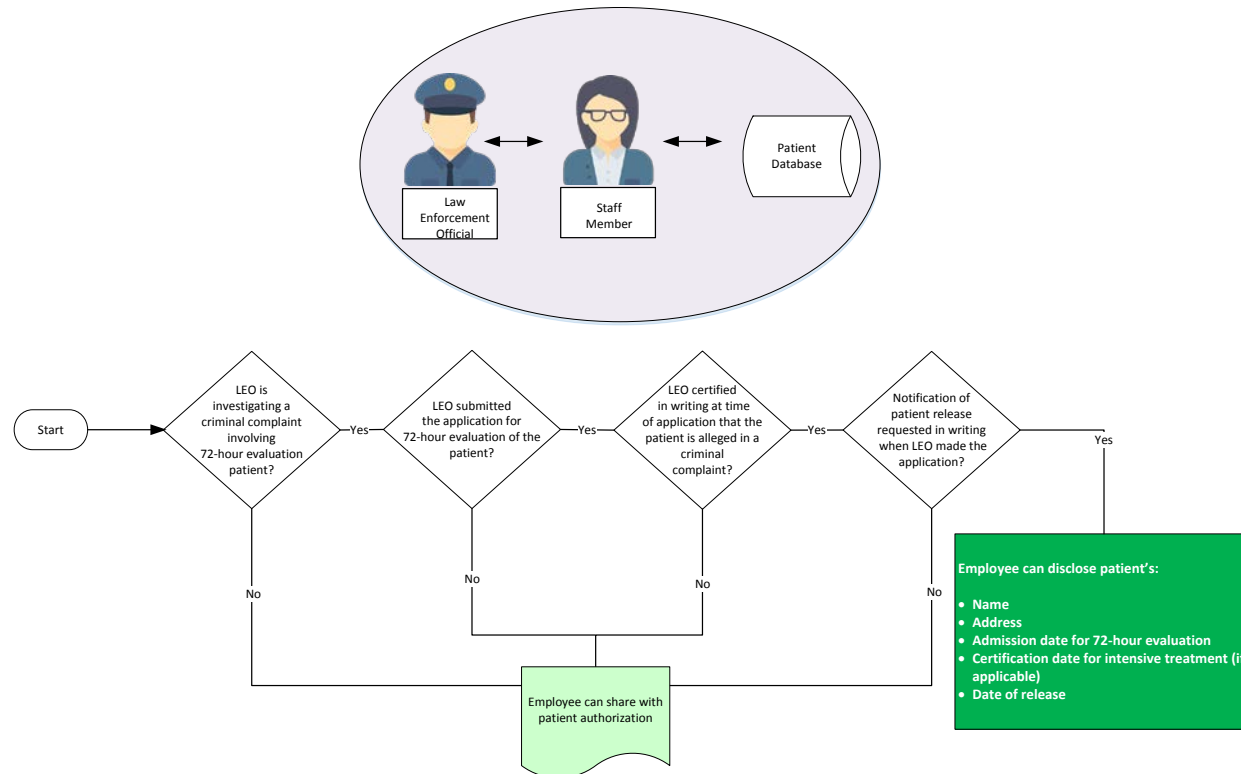
A [law enforcement official \(LEO\)](#) requests to be notified by a mental health facility employee when an adult patient is released from an involuntary 72-hour evaluation and [treatment](#).

What patient information can be shared with the law enforcement official?

Graphic - Patient Being Released from Involuntary Hospitalization

Important Scenario Guidance Assumptions:

- Employee is authorized by the facility to [access](#) patient information
- No patient or [patient representative authorization](#)
- No court order



Scenario Guidance – Patient Being Released from Involuntary Hospitalization

Employees of a mental health facility are limited by law in the information they can provide to a law enforcement official, such as police officer, sheriff's deputy or detective. Without an appropriate authorization or a sufficient court order to release information, an employee is allowed to [disclose](#) information only to notify a law enforcement official about release from a 72-hour hold of a specific patient who is under criminal investigation.

The employee may notify the law enforcement official about the release of a patient who was involuntarily detained if both of the following conditions are met:

- The law enforcement official to whom the disclosure is to be made initiated the request for 72-hour hold
- The law enforcement official also requested notification of release when the 72-hour hold was initiated

The notice is limited to:

- Person's name
- Address
- Admission date for 72-hour evaluation
- Certification date for intensive treatment (if applicable, up to 14 additional days of treatment at the discretion of the facility's professional staff)
- Date of release

[CA Welf. & Inst. § 5152.1.]

Citations and Related Guidance

- CA Welf. & Inst. § 5328(p).
- CA Welf. & Inst. § 5152.1.
- CA Welf. & Inst. § 5250.1.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Public Safety and Public Health Policy

Federal regulations and State statutes allow the disclosure of [protected health information \(PHI\)](#) to safeguard individuals and the public from serious threats to health and safety. Since such threats may initially be identified through mental health or substance use disorder (SUD) [treatment](#), privacy regulations and statutes address such situations.

In addition, public health departments and agencies create policies to fulfill their missions to protect the health and well-being of their constituents. Public health policy development often requires different types of patient data.

The extent that behavioral health information can be shared to protect public safety and to contribute to the development of public health policy is determined by how the Health Insurance Portability and Accountability Act (HIPAA), the California Medical Information Act (CMIA), the Lanterman-Petris-Short (LPS) Act and 42 C.F.R. Part 2 – Confidentiality of Substance Use Disorder Patient Records apply to the situational specifics.

Scenario 17 - Public Health and Safety

Description

Under certain circumstances, federal and State [privacy](#) laws allow [protected health information \(PHI\)](#) including patient [mental health information](#) or [substance use disorder \(SUD\) patient-identifying information](#) to be [disclosed](#) for the purpose of protecting public health and safety.

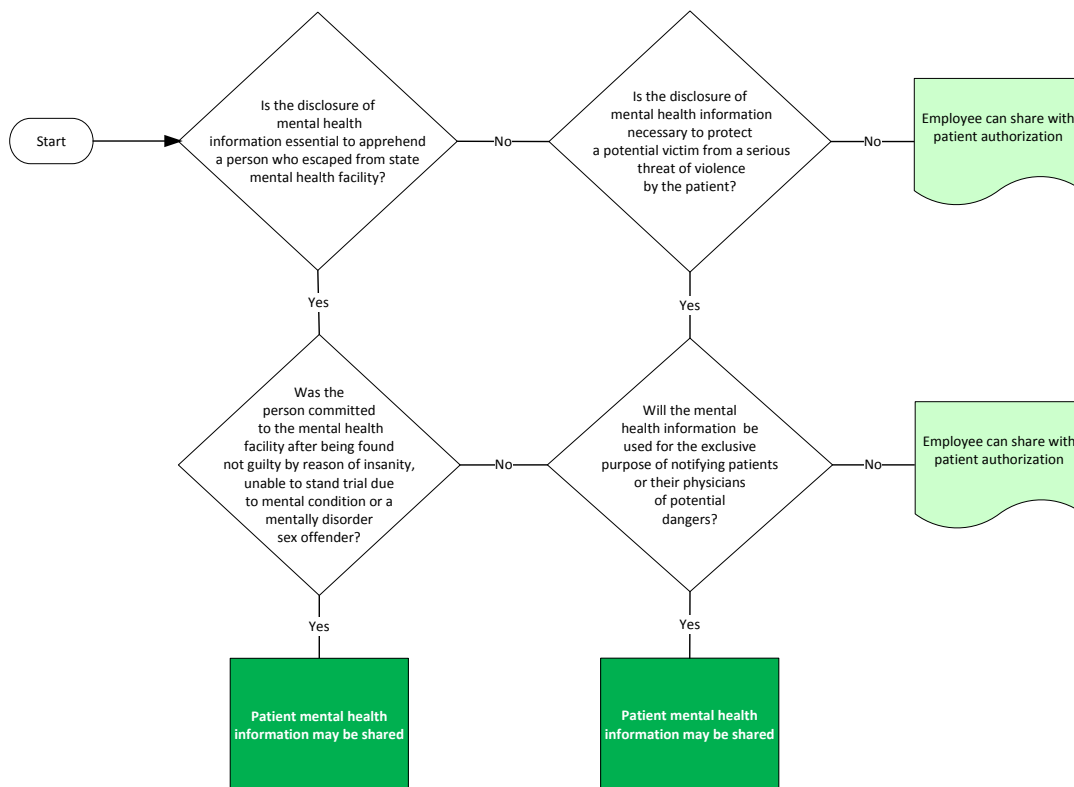
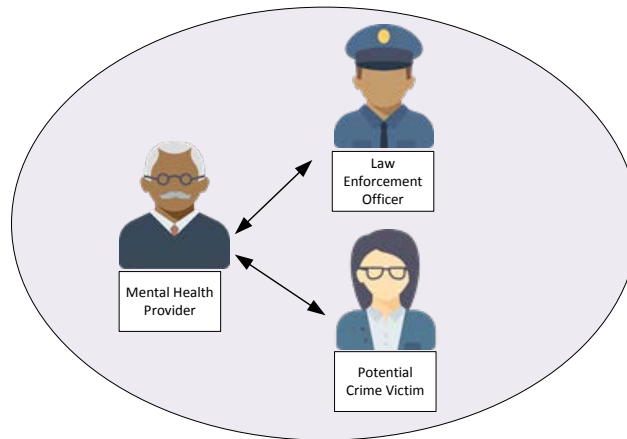
Under what circumstances can a behavioral health provider share patient health information to protect public health and safety?

Graphic - Public Health and Safety

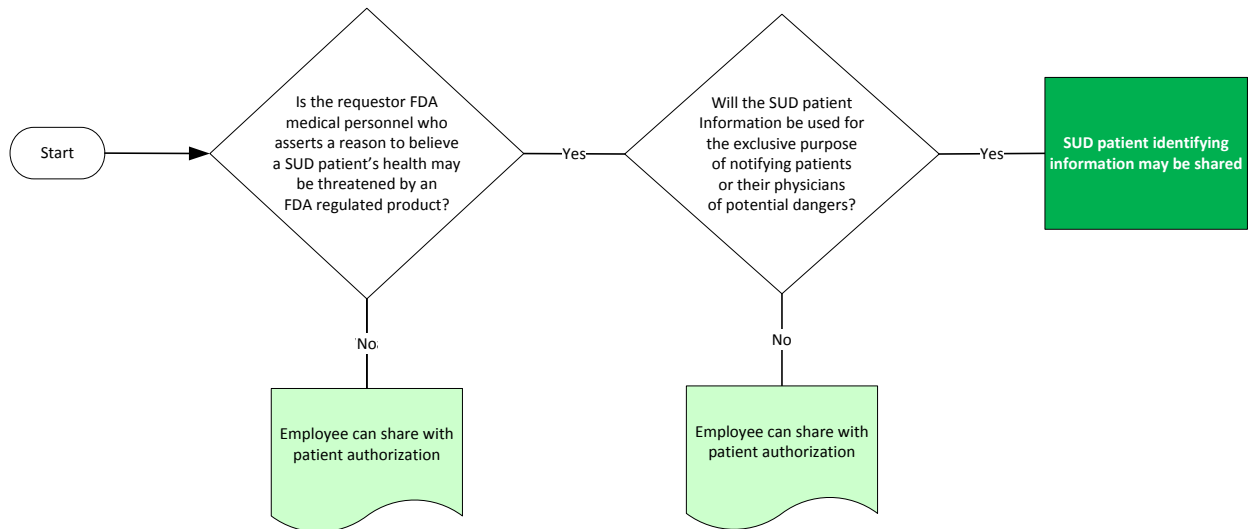
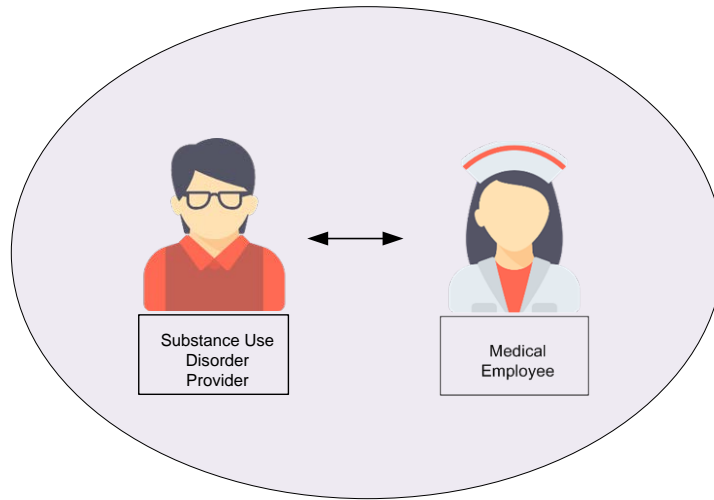
Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order

Mental Health



Substance Use Disorder



Scenario Guidance – Public Health and Safety

A patient's psychotherapist has a responsibility to protect the public and potential victims. If the psychotherapist believes a patient presents a serious danger of violence, he or she may release mental health record information to potential victims, [law enforcement officials](#), and county child welfare agencies if the psychotherapist determines the disclosure is needed to protect the health and safety of a person or the public.

Patient health information which the medical director of a [treatment](#) facility considers essential in aiding apprehension of the escapee shall be released if a person has escaped from a state mental health facility, and the person was committed to the facility by a court after being found not guilty by reason of insanity, unable to stand trial due to mental condition, or a mentally disordered sex offender.

[45 C.F.R. § 164.501; 45 C.F.R. §§ 164.508(a)(2)(ii), 164.512(b)(1) and 164.512(j)(1); CA Civ. Code § 56.10(c)(19); CA Evidence Code § 1010; CA Penal Code §§ 1026 and 1370; CA Welf. & Inst. §§ 5328(r), 6600(g), 6332, and 7325.5.]

SUD providers covered by 42 C.F.R. Part 2 may share SUD patient-identifying information with the Food and Drug Administration (FDA) to protect the health and well-being of the public. The information may be disclosed to FDA medical personnel if there is a reason to believe the health of any individual is threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction. The information can be used exclusively to notify patients or their physicians of potential dangers. For example, if a SUD patient is being treated with FDA-regulated medication that is being recalled due health risks, a SUD provider may disclose patient-identifying information to the FDA for the purpose of notifying patients or their physicians of the potential dangers.

Immediately following disclosure, the 42 C.F.R. Part 2 [SUD treatment program](#) is required to document the disclosure in the patient's records with all of the following information:

- The name of the medical personnel to whom disclosure was made and his or her affiliation with any healthcare facility
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency or product error

Patient-identifying information means the name, address, Social Security Number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information.

[42 C.F.R. § 2.51.]

Citations and Related Guidance

- 42 C.F.R. § 2.51.
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.508(a)(2)(ii).
- 45 C.F.R. § 164.512(b)(1).
- 45 C.F.R. § 164.512(j)(1).
- CA Civ. Code § 56.10(c)(18)(19).
- CA Evidence Code § 1010.
- CA Penal Code § 1026.
- CA Penal Code § 1370.
- CA Welf. & Inst. § 5328(r).
- CA Welf. & Inst. § 6332.
- CA Welf. & Inst. § 7325.5.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 18 - Public Health Policy Development

Description

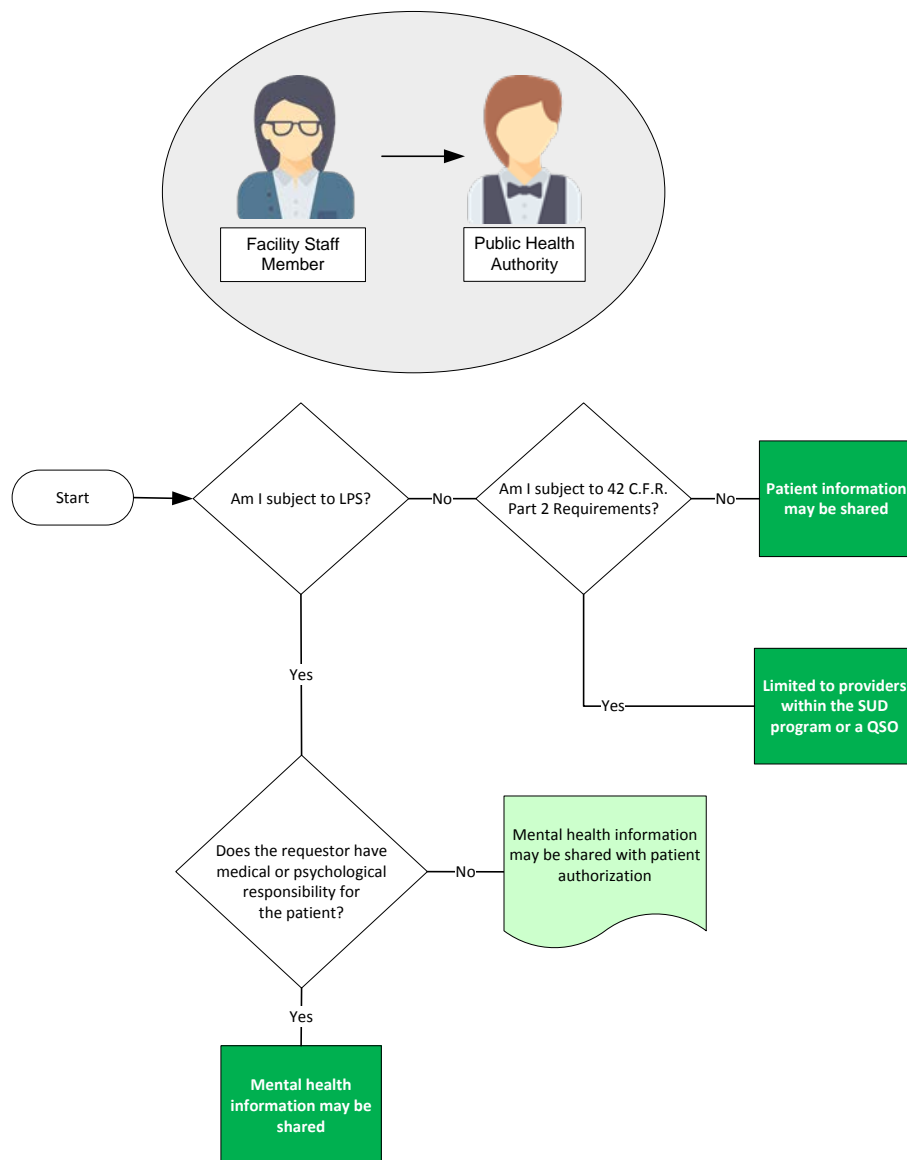
State and local health departments collect and assess the healthcare information of users of hospital emergency department care in order to evaluate trends in emergency department use to develop strategies to achieve public health objectives (e.g., to prevent hospitalization, improve [access](#) to ambulatory care, perform surveillance for new or emerging trends in diseases and conditions). Such diagnoses and other information may include mental health and [substance use disorder \(SUD\) patient-identifying information](#).

Under what circumstances can a provider share patient behavioral health information with public health departments for the purpose of developing public health programs?

Graphic - Public Health Policy Development

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order
- Exchange of information is for a purpose other than direct [treatment](#)



Scenario Guidance – Public Health Policy Development

The Health Insurance Portability and Accountability Act (HIPAA) permits, but does not require, [covered entities](#) to [disclose protected health information \(PHI\)](#) without authorization to [public health authorities](#) for public health-related activities not related to direct treatment. However, if State law prohibits or does not specifically authorize a disclosure, then the disclosure may be made only with patient or patient representative authorization.

[45 C.F.R. §§ 164.501 and 164.512(b).]

For purpose of delivering the optimal types and locations of health programs, compiled or summarized mental health and SUD patient-identifying information may be shared with public health departments if patient identities cannot be determined from the data disclosed. Patient-identifying behavioral health information, however, is specially protected health information and may only be shared under the conditions described in the following paragraphs.

Mental Health

[Mental health information](#) regulated by the Lanterman-Petris-Short (LPS) Act may be disclosed without patient authorization only by a professional employed by the treatment facility to a professional person who has medical or psychological responsibility for the patient. If this condition is not met, the mental health information can be shared only with a valid patient or patient representative authorization.

[CA Welf. & Inst. §§ 5328(a-b); § 5328.6; 45 C.F.R. §§ 164.501.]

Substance Use Disorder

SUD patient-identifying information regulated by 42 C.F.R Part 2 is highly sensitive and specially protected under federal law. Without patient authorization, disclosure is strictly regulated for any patient information that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a [SUD treatment program](#) (as defined by 42 C.F.R. Part 2) that receives federal assistance. Since federal assistance is broadly defined in regulations and includes Medicare and Medicaid [payments](#), a significant percentage of SUD patient-identifying information falls under 42 C.F.R. Part 2 regulations.

Despite the restrictions, a SUD provider may disclose information without a patient authorization if the information shared does not identify the patient as a past or current SUD patient. In addition, a SUD provider may disclose SUD patient-identifying information without a

patient authorization if the recipient is part of a [qualified service organization \(QSO\)](#). The QSO must have an appropriate written agreement in effect with the program as defined in the 42 C.F.R. Part 2 regulations. A QSO may not re-disclose SUD patient-identifying information without written authorization.

[42 C.F.R. §§ 2.11, 2.12(c)(4) and 2.32.]

If this condition is not met, the SUD patient-identifying information can be shared only with a valid SUD patient authorization. The required elements of a written authorization for the use and disclosure of SUD treatment records may be found in [Appendix 2](#).

[42 C.F.R. §§ 2.31 and 2.33.]

Citations and Related Guidance

- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(c)(4).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 2.32.
- 42 C.F.R. § 2.33.
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.512(b).
- CA Welf. & Inst. § 5328(a-b).
- CA Welf. & Inst. § 5328.6.
- [Appendix 2 - Patient Authorization for Use or Disclosure - Patient Authorization for Use or Disclosure](#)

Health Information Exchange

[Health information exchange \(HIE\)](#) is defined as the processes and methodologies to electronically move health information among different healthcare information systems and while maintaining the [integrity](#) and [security](#) of the information moved. This type of electronic exchange is usually enabled by a [health information organization \(HIO\)](#) that oversees and governs the exchange of the health information among participants and stakeholders to improve healthcare, usually within a specific region or community.

While HIOs offer benefits to participants and patients, they also introduce unique challenges with respect to managing [privacy](#) and security practices and policies. The HIO and its participants are responsible to comply with the laws protecting the privacy of mental health and [substance use disorder \(SUD\) patient-identifying information](#) as it moves within the HIO and participants' health information systems.

Some HIOs in California simply provide the services and infrastructure to pass information between HIO participants. Other HIOs maintain databases to store data and use security safeguards that appropriately controls participant [access](#) to the data. The HIO-based scenarios that follow assume the latter approach.

Scenario 19 - Substance Use Disorder Provider to Health Information Organization

Description

A substance use disorder (SUD) provider plans to store [SUD patient-identifying information](#) on a [health information exchange \(HIE\)](#) with data sharing partners to facilitate efficient, cost-effective coordinated treatment and care in a secure environment.¹¹

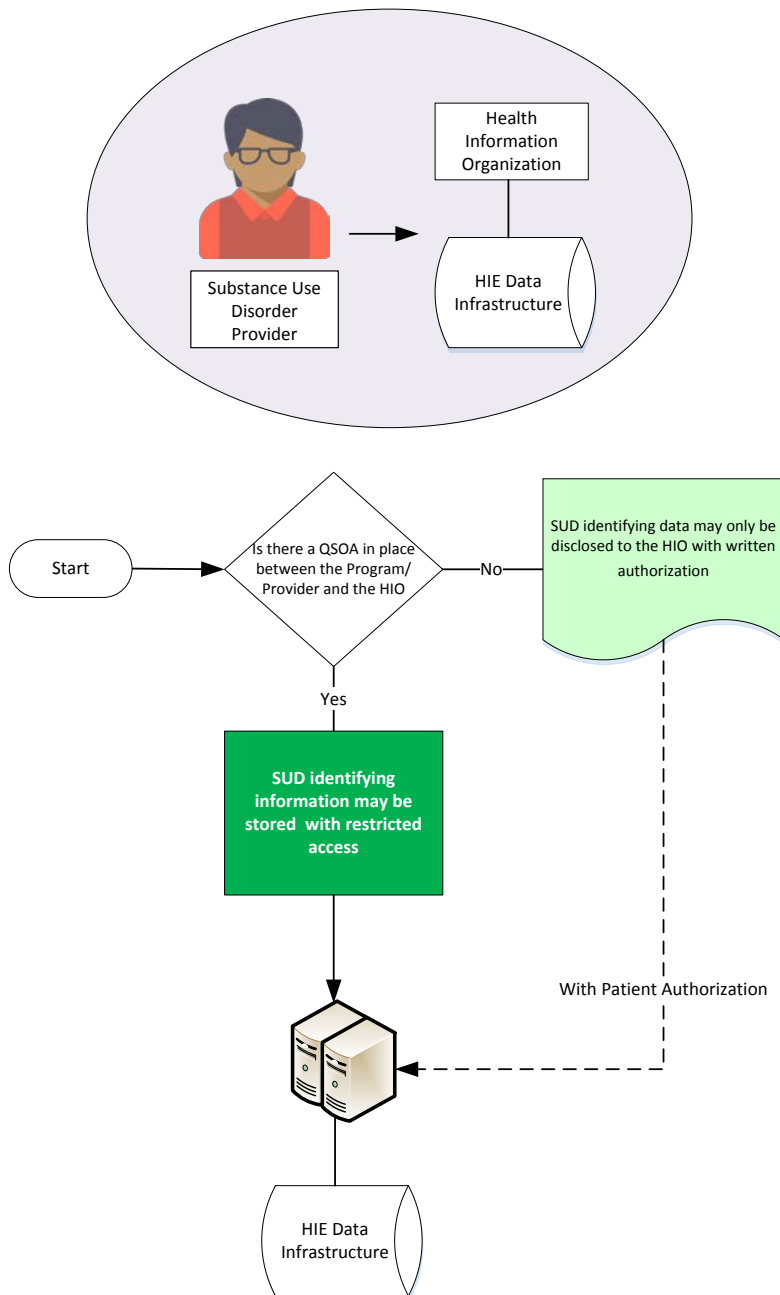
What SUD information can a substance use disorder provider share and store with a Health Information Organization (HIO)?

¹¹ For more information, see <https://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs>, a website maintained by Substance Abuse and Mental Health “Services Administration (SAMSHA) and the U.S. Department of Health and Human Services (HHS), and the imbedded link to Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange (HIE), an educational document developed by SAMSHA and HHS in collaboration with the Office of the National Coordinator for Health Information Technology (2010)

Graphic - SUD Provider to HIO

Important Scenario Guidance Assumptions:

- There is patient or [patient representative authorization](#)
- The SUD health provider is covered by 42 C.F.R. Part 2 regulations
- Data will be stored unencrypted



Scenario Guidance – SUD Provider to HIO

42 C.F.R. Part 2 applies to facilities and providers that are federally-assisted substance use disorder programs, which includes most treatment programs in California. The protected information is any information that would identify an individual as having a current or past substance use disorder. The [disclosure](#) to the HIO would only be as permitted in 42 C.F.R. Part 2. In other words, non-emergency medical situations require written authorization or a [qualified service organization agreement \(QSOA\)](#) to be in place prior to disclosing the information to the HIO.

[42 C.F.R. § 2.31(a); 42 C.F.R. §§ 2.11 and 2.12(a)(1).]

42 C.F.R. Part 2 regulations permit patient information disclosure to HIOs and other health information exchange (HIE) systems. The regulation contains specific requirements for the disclosure of information by [SUD treatment programs](#). With some exceptions, patient authorization is required.

[42 U.S.C. § 290dd-2; 42 C.F.R. Part 2.]

A SUD provider may disclose patient demographics, diagnosis, prognosis, and treatment information to an HIO to treatment/prevention program professionals *in the same facility or program*. The provider may also disclose patient information to [qualified service organizations \(QSO\)](#) that provide services to the SUD treatment program. HIOs are required to have a QSOA in place with the program/provider. It is important to note that as a legal recipient of 42 C.F.R. Part 2 information the HIO cannot contract with a QSO. A QSO is only allowed to contract with a 42 C.F.R. Part 2 program/provider.

[CA Health & Saf. § 11845.5(c)(1); 42 C.F.R. §§ 2.11 and 2.12(c)(4); 45 C.F.R. §§ 164 et seq..]

Patient authorization is required to allow an HIO to disclose the 42 C.F.R. Part 2 information to other HIO affiliated members, with certain exceptions (See [Scenario 21 - Substance Use Disorder Information from HIO to Recipient](#)). A written statement indicating the information disclosed is protected by federal law and cannot be further disclosed unless permitted by regulations must accompany each disclosure made with patient authorization. Information disclosed electronically must have an accompanying electronic notice prohibiting re-disclosure. Under 42 C.F.R. § 2.32, the statement must read:

“This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the

*written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.”*

Citations and Related Guidance

- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(a)(1).
- 42 C.F.R. § 2.12(c)(4).
- 42 C.F.R. § 2.31(a).
- 42 C.F.R. § 2.32.
- 45 C.F.R. § 164.308(b).
- 45 C.F.R. § 164.314(a).
- 45 C.F.R. § 164.501.
- 42 U.S.C. § 290dd-2.
- CA Health & Saf. § 11845.5(c)(1).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 20 - Mental Health Provider to Health Information Organization

Description

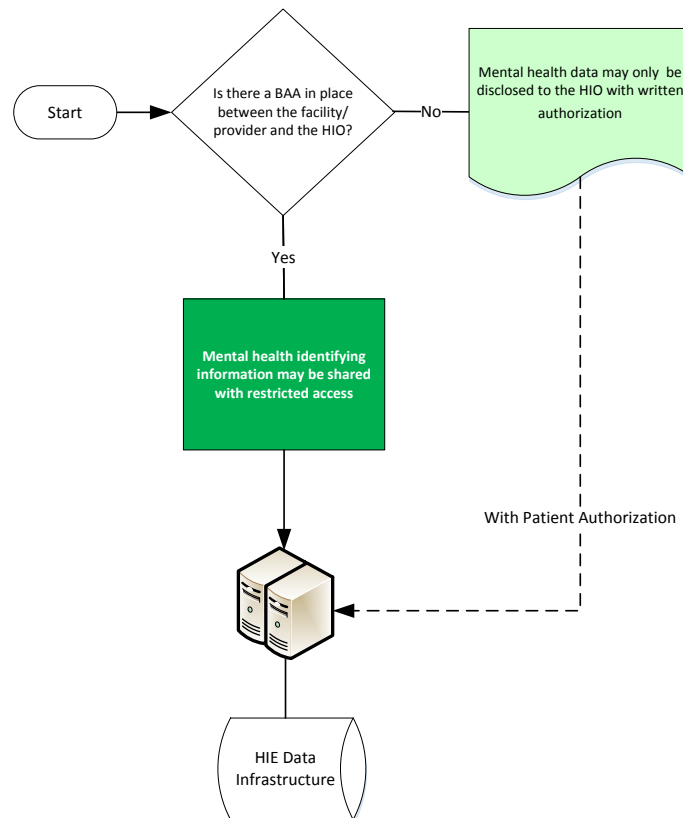
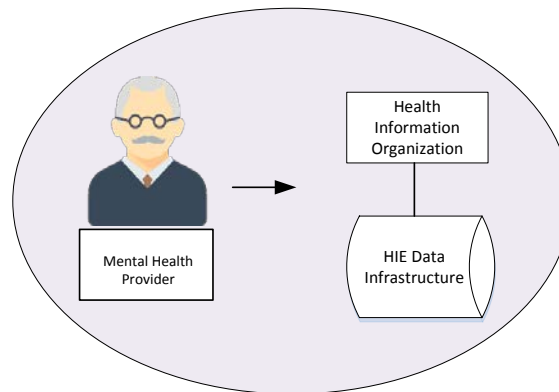
A mental health provider plans to store patient mental health information across a [health information exchange \(HIE\)](#) with data sharing partners to facilitate efficient, cost-effective coordinated [treatment](#) and care in a secure environment.

What mental health information can a mental health provider share and store with a Health Information Organization (HIO)?

Graphic - Mental Health Provider to HIO

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order
- The mental health information is covered by Lanterman-Petris-Short (LPS)
- Data will be stored unencrypted



Scenario Guidance – Mental Health Provider to HIO

The HIO and its participants are responsible to comply with the laws protecting the [privacy](#) of mental health as it moves within and across the HIE. [Mental health records](#) and related information are sensitive. In most circumstances, mental health information may only be shared with the authorization of the patient or patient representative.

[CA Civ. Code §§ 56.10(a), 56.10(c)(1), and 56.11; CA Welf. & Inst. § 5328(b)]

Despite the restrictions, facilities and providers subject to Lanterman-Petris-Short (LPS) may share information with an HIO provided a [business associate agreement \(BAA\)](#) is in place. A BAA is a valid written contract or other written agreement implemented between organizations prior to using, [disclosing](#), moving, or storing health information for health information exchange purposes. The HIO must implement safeguards to protect the privacy and [security](#) of the information as required by the Health Insurance Portability and Accountability Act (HIPAA) and California Medical Information Act (CMIA).

[CA Civ. Code §§ 56.10(a), 56.10(c)(1), and 56.11; 42 U.S.C § 17938; 45 C.F.R. §§ 164.308(b), 164.314(a), 164.501, and 164.508(a)(2).]

If the HIO does not have a BAA in place, the mental health information can be shared only with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(b-c); CA Welf. & Inst. § 5328(b).]

Citations and Related Guidance

- 45 C.F.R. § 164.308(b).
- 45 C.F.R. § 164.314(a).
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.508(a)(2)
- 42 U.S.C. § 17938.
- CA Civ. Code § 56.10(a).
- CA Civ. Code § 56.10(c)(1).
- CA Civ. Code § 56.11.
- CA Welf. & Inst. § 5328(a-c).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 21 - Substance Use Disorder Information from HIO to Recipient

Description

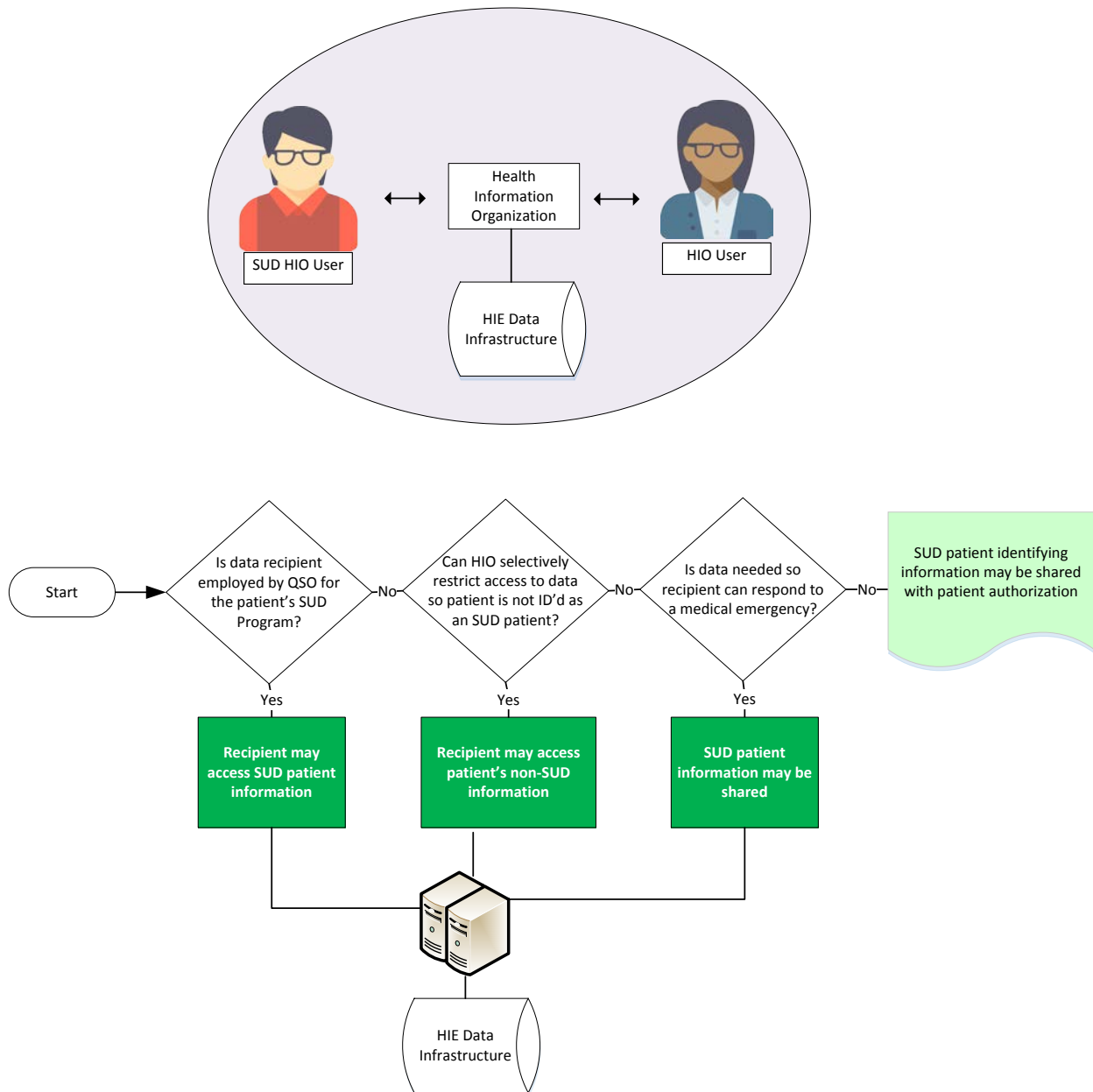
A [health information exchange \(HIE\)](#) user wants to [access substance use disorder \(SUD\) patient-identifying information](#) from a [health information organization \(HIO\)](#) database. The HIE user is a credentialed individual who has access to the information based on his or her roles and responsibilities. The HIO is in possession of and maintains secure health information. The HIO governs access to patient information through permissions specific to user roles.

Can an HIE participant access substance use disorder
patient information from an HIO?

Graphic - Substance Use Disorder Information from HIO to Recipient

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order
- The HIE participant that provided the patient information to the HIO is an SUD health provider covered by 42 C.F.R. Part 2 regulations



Scenario Guidance – Substance Use Disorder Information from HIO to Recipient

SUD patient-identifying information is highly sensitive. [Disclosure](#) without patient authorization of any patient information that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program, is strictly regulated for any [SUD treatment program](#) that receives federal assistance. Since federal assistance is broadly defined in regulations and includes Medicare and Medicaid [payments](#), a large part of SUD patient-identifying information falls under 42 C.F.R. Part 2 regulations.

Despite the restrictions, a SUD provider may share information with an HIO without a patient authorization under certain conditions (see [Scenario 19 - SUD Provider to HIO](#)).¹² Once the patient's information is stored within an HIO's database, HIE participants can access the SUD patient-identifying information without an authorization only if at least one of the following conditions is met:

- The HIO user accessing the SUD patient-identifying information is employed by a [qualified service organization \(QSO\)](#) to provide support services, such as benefit eligibility determination, population health management, arranging for medical assistance, or conduct quality improvement activities (see [Scenario 10 – Quality Improvement](#)) to the program that provided the SUD patient-identifying information to the HIO. The QSO must have an appropriate written agreement in effect with the program as defined in the 42 C.F.R. Part 2 regulations. A QSO may not re-disclose SUD patient-identifying information without written authorization. *[42 C.F.R. § 2.11; 42 C.F.R. § 2.12(c)(4); 42 C.F.R. § 2.32.]*
- The HIO user may access SUD patient health information for purposes permitted by HIPAA and CMIA if the information accessed does not allow the patient to be identified as an SUD patient directly, by reference to other publicly available information, or by verification as an SUD patient by another person. *[42 C.F.R. § 2.12(a)(1); 45 C.F.R. § 164.506; CA Civ. Code § 56.10(c).]*
- The HIO participant may access SUD patient health information for purposes of responding to a bona fide medical emergency (see [Scenario 8 - In the Event of Emergency](#)). *[42 C.F.R. § 2.51(a); 42 C.F.R. § 2.1 § 290ee-3 (b)(2)(A); CA Health & Saf. § 11845.5(c)(1).]*

¹² For more information, see <https://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs>, a website maintained by Substance Abuse and Mental Health “Services Administration (SAMSHA) and the U.S. Department of Health and Human Services (HHS), and the imbedded link to [Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange \(HIE\)](#), an educational document developed by SAMSHA and HHS in collaboration with the Office of the National Coordinator for Health Information Technology.

In the infrequent instance where the HIO user accessing the SUD patient-identifying information is employed by the program (or an organization with direct administrative control of the program) that provided the SUD patient-identifying information to the HIO, access is allowed without an authorization.

[42 C.F.R. § 2.12(c)(3).]

If at least one of the above conditions is not met, the SUD patient-identifying information can be accessed by an HIO user only with a valid SUD patient authorization. If the SUD program participating in the HIO has patient authorization to disclose the patient's SUD information to another HIO participant, the HIO does not require an additional authorization to allow the participant access to the patient's records. Based on revisions to 42 C.F.R. Part 2 from March 2017, the HIO can honor an SUD patient's authorization for a general designation, such as "to all my current, past and future treating providers," assuming the HIO can determine which participants have a treating provider relationship with the patient (for more information about 42 C.F.R. Part 2 authorization requirements, see [Appendix 2 – Patient Authorizations for Use or Disclosure](#)).

[42 C.F.R. § 2.31.]

The disclosures of SUD patient health information described above must be documented and provided to the patient upon request. The HIO, in its role as an intermediary, is required to capture the disclosure information and, upon patient request, provide a list of disclosures that have been made. In addition, the HIO must capture specific information for disclosures made for medical emergencies and notify the patient's Part 2 program.¹³

[42 C.F.R. § 2.13(d); 42 C.F.R. § 2.51(c).]

¹³ For more information, see <https://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs>, a website maintained by Substance Abuse and Mental Health "Services Administration (SAMSHA) and the U.S. Department of Health and Human Services (HHS), specifically Question 7 of the August 9, 2016 Frequently Asked Questions dated August 9, 2016, an educational document developed by SAMSHA and HHS in collaboration with the Office of the National Coordinator for Health Information Technology.

Citations and Related Guidance

- 42 C.F.R. § 2.1 § 290ee-3(b)(2)(A).
- 42 C.F.R. § 2.11.
- 42 C.F.R. § 2.12(a)(1).
- 42 C.F.R. § 2.12(c)(3-4).
- 42 C.F.R. § 2.13(d).
- 42 C.F.R. § 2.31.
- 42 C.F.R. § 2.32.
- 42 C.F.R. § 2.51(a).
- 42 C.F.R. § 2.51(c).
- 45 C.F.R. § 164.506.
- CA Civ. Code § 56.10(c).
- CA Health & Saf. § 11845.5(c)(1).
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Scenario 22 - Mental Health Information from HIO to Recipient

Description

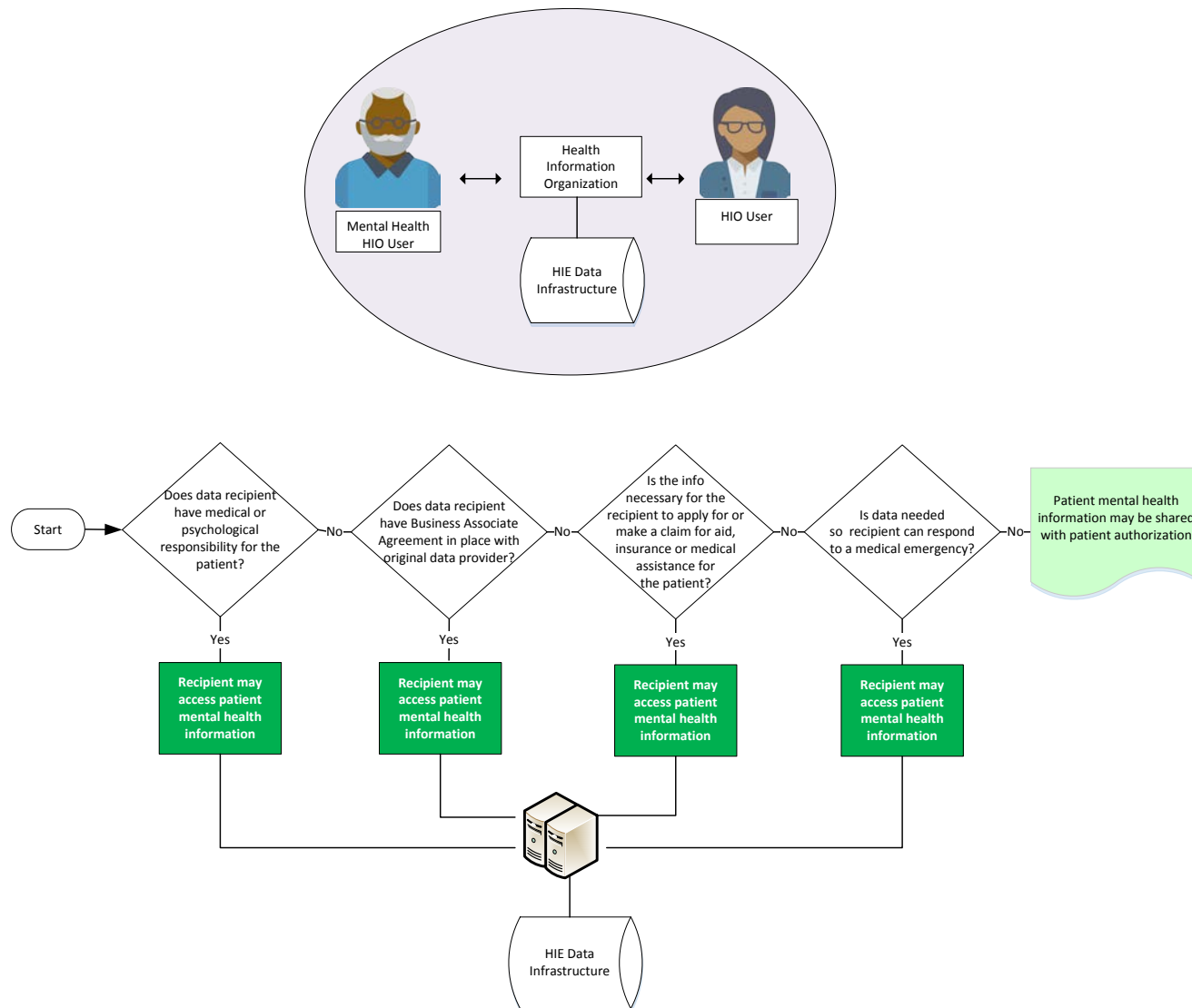
A [health information exchange \(HIE\)](#) user wants to [access](#) a patient's mental health information from a [health information organization \(HIO\)](#) database. The HIE user is a credentialed individual who has access to the information based on his or her roles and responsibilities. The HIO is in possession of and maintains secure health information. The HIO governs access to patient information through permissions specific to user roles.

Can an HIE participant access patient mental health information from an HIO?

Graphic - Mental Health Information from HIO to Recipient

Important Scenario Guidance Assumptions:

- There is no patient or [patient representative authorization](#)
- There is no court order
- The patient information the HIE participant is seeking to access in the HIO data repository is covered by the Lanterman-Petris-Short (LPS) Act



Scenario Guidance – Mental Health Information from HIO to Recipient

Mental health records and related information are sensitive. In most circumstances in California, Lanterman-Petris-Short (LPS) regulated [mental health information](#) may only be shared with the authorization of the patient or patient representative.

Despite the restrictions, a mental health provider may share information with an HIO without a patient authorization under certain conditions (See [Scenario 20 - Mental Health Provider to Health Information Organization](#)). Once the patient's information is stored within an HIO's database, however, HIE users can only access the mental health information regulated by LPS¹⁴ without an authorization if at least one of the following conditions is met:

- The HIO user accessing the mental health information is a professional providing medical or psychological [treatment](#) to the patient.
[CA Welf. & Inst. § 5328(a).]
- The HIO user accessing the mental health information has a valid [business associate agreement \(BAA\)](#) to carry out, assist with the performance of, or perform a function or activity (e.g., financial audit, IT services, quality improvement activities) on behalf of the mental health provider who submitted the patient's mental health information to the HIO. A business associate is permitted to use or disclose health information only in the manner specified in the executed BAA to protect health information in accordance with HIPAA guidelines (See [Scenario 10 – Quality Improvement](#) and [Scenario 11 – Audits](#) for more information on [business associates](#)).
[45 C.F.R. § 160.103; 45 C.F.R. §§ 164.308(b)(1-3) and 164.504.]
- The HIO user is accessing the mental health information because it is necessary to make a claim or application for aid, insurance, or medical assistance on the patient's behalf.
[CA Welf. & Inst. § 5328(c).]
- The HIO user may access the patient's health information for purposes of responding to a medical emergency (see [Scenario 8 - In the Event of Emergency](#)).
[CA Civ. Code 56.10(c)(1).]

In the infrequent instance where the HIO user accessing the mental health information is a professional person (e.g., physician, licensed psychologist, licensed professional clinical

¹⁴ Mental health information not regulated by LPS may be disclosed as permitted for other types of health information by HIPAA and CMIA.

counselor, social services case manager) providing services within the treatment program that provided the information to the HIO, no patient authorization is needed.

[CA Welf. & Inst. § 5328(a).]

If none of the above conditions are met, the mental health information regulated by LPS can only be accessed by the HIO participant with a valid patient or patient representative authorization.

[CA Welf. & Inst. § 5328(b); 45 C.F.R. § 164.501.]

If mental health information regulated by LPS is shared for any reason, the HIO must capture the [disclosure](#) in the patient's records and be able to document specifics of the disclosure, including the date, circumstance, names of recipient, relationship to patient, and what information was disclosed.

[CA Welf. & Inst. § 5328.6.]

Citations and Related Guidance

- 45 C.F.R. § 160.103.
- 45 C.F.R. § 164.308(b)(1-3).
- 45 C.F.R. § 164.501.
- 45 C.F.R. § 164.504.
- CA Civ. Code § 56.10(c)(1).
- CA Welf. & Inst. § 5328(a-c).
- CA Welf. & Inst. § 5328.6.
- [Appendix 2 - Patient Authorization for Use or Disclosure](#)

Concluding Thoughts

In conclusion, the State of California recognizes the value of sharing of healthcare information when legally permissible and in the interests of the patient. Such sharing often improves coordination of care and health outcomes to the benefit of the patient. In the current complex regulatory environment, the State recognizes it can be challenging for providers to know with certainty when the sharing of healthcare information is permissible, particularly for specially protected information such as mental health and substance use disorder patient information.

The State developed this State Health Information Guidance (SHIG) to help clarify conditions when behavioral health information may be shared without patient authorization and when such disclosures are permitted by patient authorization. The SHIG is a resource to provide such clarification and encourage appropriate sharing of behavioral health patient information for the purposes of better care coordination and improved health outcomes for patients.

As the California healthcare landscape continues to evolve and the coordination of care for behavioral health patients continues to rise, the State's intent is to support behavioral healthcare providers by clarifying State and federal law. As a result, the State wishes to contribute to the dialogue taking place among behavioral health stakeholders through this authoritative guidance so that patient-centric care solutions can continue to be developed in the behavioral health community.

Any questions or requests for additional information associated with this publication can be directed to:

Elaine Scordakis, M.S.

Assistant Director

California Office of Health Information Integrity (CalOHII)

1600 Ninth Street, Room 460

Sacramento, CA 95814

SHIGinformation@ohi.ca.gov

Appendix 1 - Thank You from the CalOHII Assistant Director

Edmund G. Brown Jr.
GOVERNOR



State of California California Office of Health Information Integrity



June 30, 2017

Dear Reader,

I am delighted to welcome you to the California State Health Information Guidance (SHIG) user community.

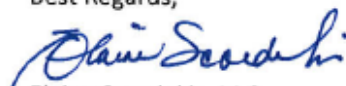
This document has been developed to provide non-mandatory guidance for State and non-state government entities and private sector healthcare organizations to clarify when patient information related to behavioral health can be shared per State and federal laws. We hope these clarifications contribute to improved coordination of patient care, better treatment outcomes, and lower healthcare costs.

The State Health Information Guidance was created by the California Health and Human Services Agency's Office of Health Information Integrity (CalOHII). CalOHII has statutory authority to interpret and clarify State and federal laws regarding health information privacy for State departments. Given this legislated responsibility, CHHS believes CalOHII is uniquely qualified to develop the SHIG for the benefit of healthcare organizations providing services in California. The development of the SHIG was made possible by a grant from the California Healthcare Foundation (CHCF), an independent, nonprofit philanthropy focused on opportunities to improve healthcare in California by supporting higher quality, greater efficiency, and broader access to care.

I am proud of our collaborative efforts and very grateful for the SHIG Advisory Group, CalOHII team and all the people who worked so diligently to create the SHIG. I particularly want to thank the scores of individuals who generously volunteered their time during the development process to provide subject matter expertise, rigorously review drafts, and provide their helpful review comments. The many individuals and organizations that contributed are listed in the pages that follow.

It is our sincere desire that the State Health Information Guidance helps provide much-needed direction to promote improved care coordination and information sharing between and among behavioral and physical healthcare providers.

Best Regards,



Elaine Scordakis, M.S.
Assistant Director

SHIG Stakeholder Kickoff Participants

The following companies and organizations participated in the SHIG Stakeholder Kickoff held in Sacramento September 2016. The purpose of the event was to explain the project and to solicit input to the topics to be covered in the SHIG:

- Alameda County Health Care Agency
- Blue Shield of California
- California Association of Health Information Exchanges (CAHIE)
- California Association of Health Plans (CAHP)
- California Department of Public Health (CDPH)
- California Hospital Association (CHA)
- California Health Information Partnership & Services Organization (CalHIPSO)
- California Health Care Foundation (CHCF)
- California Health and Human Services (CHHS) Agency
- California Office of Health Information Integrity (CalOHII)
- California Pan-Ethnic Health Network (CPEHN)
- City and County of San Francisco
- County Behavioral Health Directors Association of California (CBHDA)
- County of Santa Clara
- Department of Health Care Services (DHCS)
- Department of State Hospitals (DSH)
- Dignity Health
- LeanMD
- Manifest MedEx (formerly Cal INDEX)
- Mental Health Services Oversight & Accountability Commission (MHSOAC)
- Orion Health
- San Diego Health Connect
- San Joaquin Community Health Information Exchange (SJCHIE)
- Sutter Health

SHIG Advisory Group Members

Advisory Group members were recruited to oversee and guide the SHIG project. The Advisory Group kick off meeting was held in Sacramento November 2016. Advisory Group members include the following individuals and organizations.

Member Name	Title	Organization Name
Alya Sulaiman	Legal Counsel and Privacy Director	Manifest MedEx (formerly CalIndex)
Angela Alton	Privacy Officer	Sutter Health
Arnulfo Medina	Deputy City Attorney	City and County of San Francisco
Catherine Teare	Associate Director	California Health Care Foundation
Elaine Scordakis	Assistant Director	California Office of Health Information Integrity
Erin Bernstein	Deputy City Attorney	City and County of San Francisco
Jana Agaard	Senior Counsel	Dignity Health
Jennifer Schwartz	Privacy Officer	California Department of State Hospitals
Jonathan Rothman	Privacy Officer	California Department of Health Care Services
Josephine Wong	ACO Clinical Technical Senior Manager	Blue Shield of California
Karen Boruff	Project Manager	California Association of Health Information Exchanges
Lee Tien	Senior Staff Attorney	Electronic Frontier Foundation
Linette Scott	Chief Medical Information Officer	California Department of Health Care Services
Linnea Koopmans	Senior Policy Analyst	County Behavioral Health Director's Association of California
Lisa Matsubara	Privacy Attorney	California Medical Association
Lois Richardson	Vice President and Counsel, Privacy and Legal Publications	California Hospital Association
Martin Love	Chief Executive Officer	North Coast Health Improvement and Information Network
Mark Elson	Executive Director	San Joaquin Community Health Information Exchange
Marlies Perez	Chief, Substance Use Disorder Compliance Division	California Department of Health Care Services
Michael Freeman	Section Chief, Narcotic Treatment Program	California Department of Health Care Services

Member Name	Title	Organization Name
Michaela Lozano Lewis	Deputy County Counsel	County of Santa Clara
Michelle Befi	Customer Solutions Officer	Easter Seals Bay Area
Robert Cothern	Executive Director	California Association of Health Information Exchanges
Sara Kitterman	Privacy Officer	Sutter Health
Steven Kite	Deputy Director	National Alliance of Mental Illness

Advocacy Organizations Consulted

In addition to SHIG Advisory Group Members, CalOHII consulted select statewide and national advocacy organizations to inform the SHIG project. CalOHII had discussions and interviews with the following organizations and individuals.

Name	Title	Organization Name
Jack Dailey	Senior Attorney	Legal Aid Society of San Diego (Patient Advocacy)
Michelle De Mooy	Director, Privacy & Data	Center for Democracy and Technology (Privacy Advocacy)
Pamila Lew	Staff Attorney	Disability Rights California (Disability Advocacy)
Richard Holober	Executive Director	Consumer Federation of California (Privacy Advocacy)

SHIG Development Contributors

Under the direction of the California Office of Health Information Integrity (CalOHII) and the SHIG Advisory Group, the following individuals contributed significantly to the development of the SHIG publication.

Name	Title	Organization Name
Elaine Scordakis	Project Director	CalOHII
Jennifer Schwartz	Legal Subject Matter Expert	California Department of State Hospitals
Daniel Glaze	Project Manager/ Scrum Master	Elyon Enterprise Strategies
Jeff Turk	Content Developer	Business Advantage Consulting
Jennifer Rider	Content Developer	Business Advantage Consulting
Rick Lytle	Content Editor/Team Lead	Business Advantage Consulting
Betsy Figueiro-Steinbrueck	Contributor	Business Advantage Consulting
Rochelle Babb	Contributor	Business Advantage Consulting

Additional Organizations Consulted

The California Office of Health Information Integrity (CalOHII) and the SHIG Advisory Group greatly appreciate the services of individuals and organizations who also contributed to the development of the SHIG by consulting with the development team and/or reviewing sections of the document.

Name	Title	Organization Name
Allie Budenz	Associate Director of Quality Improvement	California Primary Care Association
Ashley Mills	Senior Researcher	California Mental Health Services Oversight and Accountability Commission
Brian Hansen	Health Program Specialist	California Department of Health Care Services
Cheri Silveira Moliere	Director, Risk Management	Xpio Group Health, LLC
Elana Lopez-Gusman	Executive Director	American College of Emergency Physicians
Karen Morphy	Chief Strategy Officer	Elyon Enterprise Strategies
Lauren Block	Program Director, Health Division	National Governors Association Center for Best Practices
Lisa Ashton	Strategic Market Director	Johnson & Johnson Health Care Systems, Inc.
Mark Wilson	Senior Consultant	Business Advantage Consulting
Mary Ellyn Gormley	Assistant County Counsel	Office of the County Counsel, County of Alameda

Appendix 2 - Patient Authorization for Use or Disclosure

Patient Authorization Summary

Although State statutes and federal regulations provide special protections for behavioral health information, they also provide flexibility for disclosing and sharing the protected information with a patient authorization. If a patient has the legal capacity to provide explicit or implicit consent or instruction, he or she generally has the right to authorize to whom his or her behavioral health and general medical information can be disclosed. A legally competent adult patient (or his or her authorized representative) may provide permission for a provider or organization to share his or her personal healthcare information, including mental health and substance use disorder (SUD) information, for a wide range of purposes, including coordination of care and social services. Providers are encouraged to discuss with patients why some forms of sharing might be in the patients' best interests. Informed disclosure decisions by patients may be beneficial to the therapeutic relationship.

As defined by healthcare privacy laws, a provider generally has responsibility to act on a patient's decisions to authorize or not authorize disclosure of personal health information in situations involving mental health or SUD. In addition, laws define conditions and required activities to obtain informed consent to share healthcare information. In some situations, questions may arise concerning whether the patient has the capacity to provide consent and if not, who is able to give informed consent for those individuals. Providers should seek legal counsel in such situations.

Depending upon the type of health information being released, authorization form requirements differ by law. Health Insurance Portability and Accountability Act (HIPAA), Lanterman-Petris-Short (LPS) Act and Confidentiality of Substance Use Disorder Patient Records (42 C.F.R. Part 2) each define required (but not identical) elements of a consent form. The requirements for a compliant authorization form from each statute or regulation are described below.

HIPAA Authorization Form Requirements

The core elements of a valid HIPAA authorization must include:

- A meaningful description of the information to be disclosed
- The name of the individual or person authorized to make the disclosure
- The name of the person/entity of the recipient of the information
- A description of the purpose of the disclosure
- An expiration date or an expiration event that relates to the individual
- A signature of the individual or their personal representative

[45 C.F.R. § 164.508(c).]

LPS Authorization Form Requirements

When a written authorization for a disclosure of mental health patient-identifying information is required, the form must include the following elements to be valid:

- The information to be released
- The name of the agency or individual to whom information will be released
- The name of the responsible individual at the mental health facility who has authorization to release information specified

[CA Welf. & Inst. § 5328.7.]

SUD Authorization Form Requirements

The written authorization for a disclosure of SUD patient-identifying information must include the following elements to be valid:

- The name of the patient
- The specific name or general description of the program making the disclosure
- The recipient of the information
- The purpose of the disclosure
- How much and what kind of information will be released, including an explicit description of the substance use disorder information that may be disclosed
- That the patient understands he or she may revoke the authorization at any time – orally or in writing
- The date or condition upon which the authorization expires, if not revoked earlier
- The date the authorization form was signed
- The signature of the patient or an authorized representative of the patient

[42 C.F.R. §§ 2.31 and 2.33.]

If an authorization form specifies the information recipients as an Accountable Care Organization (ACO) and the ACO's participants as having a treating provider relationship with the patient, the form could comply with the 42 C.F.R. Part 2 requirements. The ACO itself must be a separate entity from all of its participants and not provide treatment to the patient.

Under the revised 42 C.F.R. Part 2 rule (effective March 2017), the amount and kind of information disclosed must include "an explicit description of the substance use disorder information that may be disclosed."

[42 C.F.R. § 2.31(a)(3).]

Documentation Requirements for Authorized Disclosures

Specific documentation must be created and maintained for disclosures of mental health and SUD patient records, even when legally authorized by the patient. For example, the disclosure of mental health information protected by LPS must be documented in the patient's record.

Records Protected by LPS

The LPS Act requires documentation of disclosures in the following instances:

- Disclosure to a professional person outside of the facility that does not have medical or psychological responsibility for the patient
- Authorization form is signed by parent, guardian or authorized representative
[CA Welf. & Inst. §§ 5328(a) and 5328(d).]

When LPS-regulated¹⁵ mental health records are shared for any reason outside the treatment facility or program, the disclosure must be documented in the patient's medical records and include the following elements:

- The date
- The circumstance
- Names of recipients
- Relationship to patient
- Persons and agencies to whom such disclosure was made
- What specific information was disclosed
[CA Welf. & Inst. § 5328.6.]

Mental health information shared between qualified professional persons employed by the same facility or program and have medical or psychological responsibility for the patient's care need not be documented in the patient's medical records.

[CA Welf. & Inst. § 5328(a-b).]

Records Protected by 42 C.F.R. Part 2

All disclosures of SUD patient information must be documented in the patient's record as required by 42 C.F.R. Part 2. Patients who have consented to disclose their SUD patient-identifying health information using a general designation must be provided upon request a list of entities to which their information has been disclosed. Under 42 C.F.R. Part 2 regulations, a patient may use the designation of an individual(s) and/or entity(-ies) (e.g., "my past, current and future treating providers"). Requests must be in writing and limited to disclosures within the past two years. Since HIPAA requires an accounting of disclosures to be available for six years, records should be maintained longer than two years. Each document disclosure must include:

- The name(s) of the entity(ies)
- The date of the disclosure
- A brief description of the SUD patient-identifying information disclosed
[42 C.F.R. § 2.13(d); 42 C.F.R. § 2.31(a)(4)(iii)(B)(3); 45 C.F.R. §§ 164.502 and 164.528.]

¹⁵ See [Who Is Subject to LPS](#)

Re-Disclosure of LPS and 42 C.F.R. Part 2 Patient Information

Behavioral health information regulated by 42 C.F.R. Part 2 and LPS is specially protected and, once received, may only be re-disclosed under specific conditions. Health information that identifies either directly or indirectly a patient as having been diagnosed, treated or referred for treatment for a substance use disorder requires each subsequent disclosure be made with written consent from the patient or patient's representative. The recipient of the information cannot make subsequent disclosure unless permitted by law. Mental health information covered by LPS may be re-disclosed on if the recipient has responsibility for the patient's medical or psychiatric care.

[42 C.F.R. § 2.31(a); 42 C.F.R. § 2.32; 42 C.F.R. § 2.35; CA Welf. & Inst. § 5328(a); CA Health & Saf. § 11845.5(c)(1).]

The following written statement must accompany each disclosure of substance use disorder identifying information made with the patient's written consent:

This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

Appendix 3 - Additional Resources

The State Health Information Guide (SHIG) has been posted on the California Office of Health Information Integrity (Cal OHII) website as a public resource at the following link:

[CalOHII Website](#)¹⁶. The online SHIG will be available for as long as the public and the behavioral healthcare community find it useful. CalOHII is not currently responsible to keep the SHIG current or maintain its sustainability.

Issues and Subjects Not Addressed in SHIG

The current version of the SHIG only provides clarifications relating to disclosure and exchange of behavioral health information. A significant number of issues and subjects relating to other specially-protected healthcare information were identified as complex and at times confusing for providers. Fortunately, the SHIG is designed to be a virtual binder that can be expanded to include other topics. Should funding and resources become available, useful future topics for clarification could include, but are not limited to, any or all of the following:

- HIV/AIDS
- Minors' Health Information
- Foster Children Health Information
- Developmental Services
- Criminal Justice and Corrections Patient Health Information
- Genetic Information
- Sharing within and between Health Plans, Health Information Exchanges, Health Information Organizations, Health Care Organizations, Accountable Care Organizations
- Privacy and Electronic Health Records
- Electronic Signatures

Fine Print: Rules for Exchanging Behavioral Health Information in California in 2015

This thoughtful white paper, sponsored by the California Health Care Foundation, describes misconceptions about State and federal laws governing disclosure of behavioral health information. The authors identified the need for State clarification to ease provider confusion as they interpret and apply privacy regulations. The SHIG team found it extraordinarily helpful and relevant. A link to the document as a PDF file follows:

[Fine Print: Rules for Exchanging Behavioral Health Information in California in 2015](#)¹⁷

¹⁶ <http://www.chhs.ca.gov/OHII/Pages/default.aspx>

¹⁷ [http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FinePrintExchangingBehavioral.p
df](http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FinePrintExchangingBehavioral.pdf)

Getting the Right Information to the Right Health Care Providers at the Right Time – A Road Map for States to Improve Health Information Flow between Providers

This National Governor’s Association Road Map¹⁸ document describes market and legal barriers that inhibit the exchange of patient health information and outlines approaches for states to provide better care coordination through patient information exchange, including publication of regulatory guidance. California Health and Human Services and CalOHII have taken the guidance approach through development of the SHIG.

Following is a link to the entire document, with a one-page summary provided on the next page:

[Getting the Right Information to the Right Health Care Providers at the Right Time¹⁹](#)

¹⁸ Johnson, K., Kelleher, C., Block, L., & Isasi, F. (2016) Getting the Right Information to the Right Health Care Providers at the Right Time: A Road Map for States to Improve Health Information Flow Between Providers. Washington, DC: National Governors Association Center for Best Practices.

¹⁹ <https://www.nga.org/files/live/sites/NGA/files/pdf/2016/1612HealthCareRightInformation.pdf>

Getting the Right Information to the Right Health Care Providers at the Right Time: A Road Map for States to Improve Health Information Flow Between Providers

The Importance of Health Information Flow Between Providers:

Exchange of clinical health information is critical to ensuring that providers have the best information possible when making decisions about patient care, minimizing repetition and errors, ensuring high-quality transitions of care and lowering costs.

The Problem:

The United States has experienced significant advancements in medical diagnostics and treatments for complex health problems in recent years; however, health care still lags far behind other sectors of the economy in the exchange of information to improve efficiency. Due to a variety of legal and market-based barriers, exchange of clinical health information between providers often does not occur, or occurs in a manner that does not allow for meaningful use of data to support optimal patient care.

The Purpose:

The road map was developed to activate governors and their senior state leaders to drive forward policies that support the seamless flow of clinical patient health care information between providers while protecting patient privacy, as a step toward nationwide interoperability.

The Audience:

The road map was developed for:

- Governors
- Governors' senior health policy officials
- State lawmakers
- State health information technology officials
- State legislative counselors

Key Content:

The road map provides state leaders:

- A series of five steps to identify and address the major barriers to clinical information flow
- Legal and market-based strategies to address barriers and a high-level assessment of effectiveness of the strategies
- State examples of successful strategies
- Measures to evaluate progress

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Appendix 4 - Definitions

Term	Definition
Access	<p><i>IT related:</i> The ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource. [source: 45 C.F.R. § 134.304.]</p> <p><i>Non-IT related:</i> The right of an individual, or his or her patient representative, to inspect and/or obtain a copy of the individual's health information. [source: 45 C.F.R. § 164.524.]</p>
Administrative Safeguards (security)	<p>Administrative actions, policies, and procedures to manage the selection, development, implementation, and maintenance of security measures to protect electronic health information, and to manage the conduct of the covered entity's or business associate's workforce in relation to the protection of that health information. [source: 45 C.F.R. § 164.306(d)(3).]</p>
Authorization	<p><i>IT related:</i> the act of granting a user, program, process or device access to information assets after proper identification and authentication are obtained. [source: CA CIO website http://www.cio.ca.gov/OIS/Government/definitions.asp]</p> <p><i>Non-IT related:</i> a detailed document that gives covered entities permission to use protected health information for specified purposes or to disclose protected health information to a third party specified by the individual. [source: 42 C.F.R. §§ 2.31 and 2.33; 45 C.F.R. § 164.508; CA Welf. & Inst. § 5328.7.]</p>
Availability	<p>The reliability and accessibility of information assets to authorized personnel in a timely manner. [source: CA CIO website http://www.cio.ca.gov/OIS/Government/definitions.asp; and 45 C.F.R. § 164.304.]</p>
Behavioral Health	<p>the blending of substance (alcohol, drugs, inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services. For purposes of the SHIG, behavior health includes mental health and substance use disorder (SUD). [source: 25 U.S. Code § 1603, paraphrased by SHIG team.]</p>
Behavioral Health Information	<p>Substance use disorder (SUD) patient-identifying information or mental health information regulated by Lanterman-Petris-Short (LPS).</p>
Business Associate	<p>A person or entity that performs certain functions or activities that involve the use or disclosure of health information on behalf of, or provides services to, a covered entity. A member of the covered entity's workforce is not a business associate. [source: 45 C.F.R. § 160.103.]</p>
Business Associate Agreement (BAA)	<p>A contract between a HIPAA-covered entity and a HIPAA business associate. The contract protects health information in accordance with HIPAA guidelines. [source: 45 C.F.R. § 164.504(e).]</p>
Confidentiality	<p>A security and privacy principle that works to ensure that information is not disclosed to unauthorized persons. [source: CA CIO website http://www.cio.ca.gov/OIS/Government/definitions.asp; and 45 C.F.R. § 164.304]</p>
Coordination of Care	<p>The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services.</p>

Term	Definition
	<i>[source: Agency for Healthcare Research and Quality website https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html]</i>
Covered Entity	<p>The following individuals or organizations that directly handle health information or Personal Health Records (PHRs):</p> <ul style="list-style-type: none"> • a health Plan • a healthcare clearinghouse • a healthcare provider who transmits any health information in electronic form in connection with a standard transaction covered by HIPAA. <p><i>[source: 45 C.F.R. § 160.103.]</i></p>
Data Use Agreement (DUA)	<p>An agreement required by HIPAA, which must be entered into before there is any use or disclosure of a limited data set to a third party. A DUA must:</p> <ul style="list-style-type: none"> • establish the permitted uses and disclosures of the limited data set; • establish who is permitted to use or receive the limited data set; and • provide that the recipient will <ul style="list-style-type: none"> ○ not use or disclose the information other than as permitted by the DUA or as otherwise required by law; ○ use appropriate safeguards to prevent uses or disclosures of the information that are inconsistent with the DUA; ○ report to the covered entity any use or disclosure of the information, in violation of the DUA, of which it becomes aware; ○ ensure that any agents to whom it provides the limited data set agree to the same restrictions and conditions; and ○ not attempt to re-identify the information or contact the individual. <p><i>[source: 45 C.F.R. § 164.514(e)(4).]</i></p>
De-identified Information	<p>Information redacted to remove any identifying information and prevent the information from being used to re-identify the patient. This process of de-identification mitigates privacy risks to patients and thereby supports the secondary use of data for comparative effectiveness studies, policy assessment, life sciences research and other endeavors.</p> <p><i>[source: HHS website https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification; and 45 C.F.R. §164.514(a) (paraphrased)]</i></p>
Disclose or Disclosed	<p>The release, disclosure, transfer, dissemination, or to otherwise communicate all or any part of any record orally, in writing, or by electronic or any other means to any person or entity.</p> <p><i>[source: 45 C.F.R § 160.103.]</i></p>
Federally Qualified Health Center (FQHC)	<p>Community-based and patient-directed organization that serves a population that is medically underserved by providing comprehensive primary health services. These organizations must qualify for funding under Section 330 of the Public Health Service Act (PHS).</p> <p><i>[source: 42 U.S.C. § 254b.]</i></p>
Health Information Exchange (HIE)	<p>The capability to electronically move health information among disparate healthcare information systems, and maintain the meaning of the information being exchanged. The goal of HIE is to facilitate access to, and retrieval of, clinical data to provide safe, timely, efficient, effective, equitable and patient-centered care.</p> <p><i>[source: Health Information Exchange http://www.himss.org/library/health-information-exchange.]</i></p>

Term	Definition
Health Information Organization (HIO)	<p>An organization that oversees and governs the exchange of health information among stakeholders within a defined geographic area, for improving health and care in that community.</p> <p>[source: HIMSS website http://www.himss.org/library/health-information-exchange.]</p>
Health Oversight Activities	<p>The oversight of the healthcare system (public or private), as well as government benefit programs, entities subject to government regulatory programs and entities subject to civil rights laws. These oversight activities include:</p> <ul style="list-style-type: none"> • audits • civil, administrative or criminal investigations • inspections • licensure or disciplinary action • civil, administrative or criminal proceedings or actions <p>[source: 45 C.F.R. § 164.512(d)(1) (paraphrased).]</p>
Health Oversight Agency	<p>A person, or entity, at any level of the federal, state, local, or tribal government that oversees the healthcare system or requires health information to determine eligibility, or compliance, or to enforce civil rights laws. Examples include:</p> <ul style="list-style-type: none"> • State health professional licensure agencies • Department of Justice and their civil rights enforcement activities • State Medicaid fraud control units • Food and Drug Administration • State licensing boards to the extent granted authority under state law <p>[source: 45 C.F.R. § 164.501 (paraphrased).]</p>
Healthcare Operations (Healthcare Business Operations)	<p>Activities relating to covered functions of a business associate, healthcare clearinghouse, healthcare plan, healthcare provider or hybrid entity. Including, but not limited to:</p> <ul style="list-style-type: none"> • conducting quality assessment and improvement activities; patient safety activities; population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, contacting of healthcare providers and patients with information about treatment alternatives; and related functions that do not include treatment • licensing and accreditation • reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, health plan performance, training of non-healthcare professionals, accreditation, certification, licensing, or credentialing activities • underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for healthcare • conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs • business planning and development • business management and general administrative activities of the entity. <p>[source: 45 C.F.R. § 164.501; CA Civ. Code § 56.10(c).]</p>

Term	Definition
Healthcare Plan (Health Plan)	<p>An individual or group plan that provides, or pays the costs of, medical care and includes the following, singly or in:</p> <ul style="list-style-type: none"> • a group plan, a health insurance issuer, a healthcare service plan • an HMO • Part A, B or D of the Medicare program, or a supplemental policy thereof • a long-term care policy excluding a nursing home fixed indemnity policy • an employee welfare benefit plan • a healthcare program for uniformed services • a veterans healthcare program • an Indian Health Services program • the Federal Employees Health Benefits Program • an approved state child health plan • a Medicare Advantage program • a high risk pool established under state law to provide health insurance coverage or comparable coverage • any other individual or group plan or combination of individual or group plans that provides or pays for the cost of medical care <p><i>[source: 45 C.F.R. § 160.103; CA Civ. Code § 56.05.]</i></p>
Healthcare Provider	<p>Any person or organization that furnishes, bills, or is paid for healthcare in the normal course of business.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • doctors • clinics • psychologists • dentists • chiropractors • nursing homes • pharmacies <p>Healthcare providers must comply with HIPAA in connection with HIPAA-covered transactions.</p> <p><i>[source: 45 C.F.R. § 160.102, and § 160.103.]</i></p>
Integrity	<p>The property that data or information have not been altered or destroyed in an unauthorized manner.</p> <p><i>[source: 45 C.F.R. § 164.304.]</i></p>
Law Enforcement Official	<p>An officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision or a state or territory, or an Indian tribe, who is empowered by law to:</p> <ul style="list-style-type: none"> • investigate or conduct an official inquiry into a potential violation of law, or • prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law. <p><i>[source: 45 C.F.R. § 164.103.]</i></p>
Limited Data Set	<p>Health information that excludes the following direct identifiers of the patient, or of relatives, employers, or household members of the patient:</p> <ul style="list-style-type: none"> • names • postal address information, other than town or city, state, and zip code • telephone and fax numbers • electronic mail addresses • Social Security Numbers • medical record numbers

Term	Definition
	<ul style="list-style-type: none"> health plan beneficiary numbers account numbers certificate / license numbers vehicle identifiers and serial numbers, including license plate numbers device identifiers and serial numbers web universal resource locators (URLs) internet protocol (IP) address numbers biometric identifiers, including finger and voice prints full face photographic images and any comparable images <p>[source: 45 C.F.R. § 164.514(e)(2).]</p>
Mental Health Professional	<p>Licensed professional, or social worker with a master's degree in social work, responsible for providing patient services under the following provisions of California's Welfare and Institutions Code:</p> <ul style="list-style-type: none"> Division 4 and 5 (concerning mental health services) Division 6 (concerning voluntary admissions to state hospitals) Division 7 (concerning psychiatric services in county hospitals) <p>[source: CA Welf. & Inst. § 5328.]</p>
Mental Health Information (Regulated by LPS)	<p>Information and records related to all involuntary treatment; all voluntary treatment at a state or local hospital, developmental center, psychiatric hospital or unit, obtained in the course of providing services under the following provisions of California's Welfare and Institutions Code:</p> <ul style="list-style-type: none"> Division 4 and 5 (concerning mental health services) Division 6 (concerning voluntary admissions to state hospitals) Division 7 (concerning psychiatric services in county hospitals) <p>[source: CA Civ. Code § 56.104; CA Welf. & Inst. § 5328.]</p>
Minimum Necessary	<p>The amount of information, to the extent necessary, to accomplish the intended purpose of a use, disclosure or request.</p> <p>[source: 45 C.F.R. § 164.502(b), and § 164.514(d).]</p>
Notice of Privacy Practices	<p>The HIPAA Privacy Rule requires health plans and covered healthcare providers to develop and distribute a notice that provides a clear, user friendly explanation of individuals' rights with respect to their personal health information and the privacy practices of health plans and healthcare providers.</p> <p>[sources: 45 C.F.R. § 160.520; HHS website: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/]</p>
Organized Health Care Arrangement	<p>A clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider.</p> <p>[source: 45 C.F.R. § 160.103.]</p>

Term	Definition
Patient's Representative	<p>A person who:</p> <ul style="list-style-type: none"> has the authority under law to make healthcare decisions for another person, or has the authority to administer the estate of a deceased person (including execution administrator) <p>An individual <i>should not</i> be treated as the patient's representative, if:</p> <ul style="list-style-type: none"> there is a reasonable belief that the individual has or will abuse/neglect/treat the patient with violence, and may endanger the patient if the information is provided to the individual, and it would not be in the best interest of the patient to treat the individual as the patient's representative <p>[source: 45 C.F.R. § 164.502(g) and HHS website http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/personalreps.html]</p>
Payment	<p>The activities undertaken by:</p> <ul style="list-style-type: none"> a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan (except as prohibited under § 164.502(a)(5)(i)); or a healthcare provider or health plan to obtain or provide reimbursement for the provision of healthcare. <p>[source: 45 C.F.R. § 164.501; CA Civ. Code § 56.10(c).]</p>
Person	<p>A natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.</p> <p>[source: 45 C.F.R. § 160.103.]</p>
Physical Healthcare Provider	<p>A healthcare practitioner who provides services for the prevention, diagnosis, treatment and rehabilitation of patients' physical illnesses and injuries. Examples include, but are not limited to, general practice physician, internist, surgeon, oncologist, radiologist, and physical therapist.</p> <p>[source: SHIG Team - for SHIG purposes only.]</p>
Primary Care Provider (PCP)	<p>A healthcare practitioner who is a patient's main, non-emergency healthcare provider. A PCPs role is to:</p> <ul style="list-style-type: none"> provide preventative care and teach healthy lifestyle choices identify and treat common medical conditions make referrals to medical specialists when necessary <p>[source: National Institutes of Health website https://medlineplus.gov/ency/article/001939.htm]</p>
Privacy	<p>The right of individuals and organizations to control the collection, storage, and dissemination of information about themselves.</p> <p>[source: California CIO website http://www.cio.ca.gov/OIS/Government/definitions.asp]</p>
Program	<p>Synonymous with "Substance Use Disorder Treatment Program" - An individual, entity, or identified unit within a general medical facility providing, or publically claiming to provide, substance use disorder diagnosis, treatment or referral for treatment; or medical personnel or other staff in a general medical care facility whose primary function is to provide substance use disorder diagnosis, treatment or referral for treatment.</p> <p>[source: 42 C.F.R. § 2.11.]</p>

Term	Definition
Protected Health Information (PHI)	Individually identifiable health information held or maintained by a covered entity or its business associates that is transmitted or maintained in any form or medium (including the individually identifiable health information of non-U.S. citizens). This includes identifiable demographic and other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of healthcare to an individual that is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse. <i>[source: 45 C.F.R. § 160.103.]</i>
Psychotherapy Notes	Notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private or group, joint or family counseling session and that are separated from the rest of the individual's medical record. <i>Note: Medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and summary information (diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date) are NOT considered psychotherapy notes.</i> <i>[source: 45 C.F.R. § 164.501.]</i>
Qualified Healthcare Professional	An individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. In addition to physicians, other qualified healthcare providers include (but are not limited to): nurse practitioner (NP), certified registered nurse anesthetist (CRNA), certified registered nurse (CRN), clinical nurse specialist (CNS), and physician assistant (PA). <i>[source: 42 C.F.R. § 480.101.]</i>
Qualified Professional Persons	Persons whose training and experience are appropriate to the nature and level of work in which they are engaged and have responsibility for the patient's care whether internal or external to the facility. May be physician, licensed psychologist, licensed professional clinical counselor, or non-clinician professionals. <i>[source: CA Welf. & Inst. § 5328(a).]</i>
Qualified Service Organization (QSO)	An individual or entity who: 1) provides services to a 42 C.F.R. Part 2 program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, accounting, population health management, medical staffing, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and 2) has entered into a written agreement with a 42 C.F.R. Part 2 program under which that individual or entity: (i) acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the 42 C.F.R. Part 2 program, it is fully bound by the regulations in this part; and (ii) if necessary, will resist in judicial proceedings any efforts to obtain access to patient-identifying information related to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by the regulations in this part. <i>[source: 42 C.F.R. § 2.11.]</i>

Term	Definition
Qualified Service Organization Agreement (QSOA)	<p>A written agreement between a 42 C.F.R. Part 2 program and a Qualified Service Organization (QSO) that permits the exchange of patient-identifying information without consent. Under the QSOA, the QSO agrees to:</p> <ul style="list-style-type: none"> a) comply with 42 C.F.R. Part 2 regulations b) resist any judicial efforts to obtain access to patient records except as permitted by law <p><i>[source: 42 C.F.R. § 2.11 (paraphrased).]</i></p>
Research	<p>A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge.</p> <p><i>[source: 45 C.F.R. § 164.501.]</i></p>
Security	<p>The administrative, physical and technical safeguards in, or protecting, an information system.</p> <p><i>[source: 45 C.F.R. § 164.304.]</i></p>
Specially Protected Health Information	<p>Any information regarding a patient's medical history, mental or physical condition, or medical treatment or diagnosis by a healthcare professional that requires special protections under the law, including substance use disorder treatment records, mental health records, psychotherapy notes, behavioral health records, HIV, AIDS, and genetic information.</p> <p><i>[source: American Health Information Management Association website http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_016464.hcsp?dDocName=bok1_016464 (paraphrased).]</i></p>
Substance Use Disorder Regulations	<p>Federal regulations found in the "Confidentiality of Substance Use Disorder Patient Records regulations."</p> <p><i>[source: 42 C.F.R. § 2.12.]</i></p>
Substance Use Disorder (SUD) Treatment Program	<p>Synonymous with "Program" - An individual, entity, or identified unit within a general medical facility providing, or publically claiming to provide, substance use disorder diagnosis, treatment or referral for treatment; or medical personnel or other staff in a general medical care facility whose primary function is to provide substance use disorder diagnosis, treatment or referral for treatment.</p> <p><i>[source: 42 C.F.R. § 2.11.]</i></p>
Substance Use Disorder (SUD) Patient-Identifying Information	<p>Any information that:</p> <ul style="list-style-type: none"> • identifies a patient as an substance use disorder either directly, by reference to other publicly available information, or through verification of such an identification by another person; • is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972; or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or is obtained prior to this date and maintained by such a treatment program after this date as part of an ongoing treatment episode which extends past this date); and • is for the purpose of treating substance use disorder, making a diagnosis for this treatment, or making a referral for this treatment. This includes patient alcohol and drug abuse treatment records as referenced in applicable state law. <p><i>[source: 42 C.F.R. Part 2 § 2.12(a)(1).]</i></p>

Term	Definition
Treatment	The provision, coordination, or management of healthcare and related services by one or more healthcare providers, including the coordination or management of healthcare by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for healthcare from one healthcare provider to another. <i>[source: 45 C.F.R. § 164.501.]</i>
Whole Person Care (WPC)	The coordination of physical health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved health and well-being through more efficient and effective use of resources. <i>[source: DHCS website http://www.dhcs.ca.gov/provgovpart/Documents/WPCProgramOverview.pdf]</i>

Appendix 5 - Acronyms

Acronym	Meaning
42 C.F.R. Part 2	Code of Federal Regulations Title 42 Part 2 – Confidentiality of Substance Use Disorder Patient Records
ABO	Blood types A, B and O
ACO	Accountable Care Organization
AOD	Alcohol and Other Drug programs
BAA	Business Associate Agreement
CA	Two-letter abbreviation for California
CAHIE	California Association of Health Information Exchanges
CAHP	California Association of Health Plans
CalHIPSO	California Health Information Partnership & Services Organization
CalOHII	California Office of Health Information Integrity
CBHDA	County Behavioral Health Directors Association of California
C.F.R.	Code of Federal Regulations
CHA	California Hospital Association
CHCF	California Health Care Foundation
CHHS	California Health and Human Services
CMIA	Confidentiality of Medical Information Act
CPEHN	California Pan-Ethnic Health Network
DEA	Drug Enforcement Agency
DHCS	Department of Health Care Services
DSH	Department of State Hospitals
DUA	Data Use Agreement
EMR	Electronic Medical Record
EMS	Emergency Medical Services
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act
HSC	Health and Safety Code
IP	Internet Protocol
IPA	Information Practices Act
IRS	Internal Revenue Service
LPS	Lanterman–Petrus–Short Act
MHSOAC	Mental Health Services Oversight & Accountability Commission
MOU	Memorandum of Understanding
NIST	National Institute of Standards and Technology
OHCA	Organized Health Care Arrangement

Acronym	Meaning
PAHRA	Patients Access to Health Records Act
PCP	Primary Care Physician
PHI	Protected Health Information
QSO	Qualified Service Organizations
QSOA	Qualified Service Organization Agreement
SHIG	State Health Information Guidance
SHIPM	Statewide Health Information Policy Manual
SP	Special Publication
SSCM	Social Services Case Manager
SUD	Substance Use Disorder
TPO	Treatment, Payment, and Operations
URL	Universal Resource Locators
WIC	Welfare and Institutions Code
WPC	Whole Person Care